

03193

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03175

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Lutie	Middle Margaret	Last Alter	2a. DATE OF DEATH Month March	Year 2-1-68	2b. HOUR 10:20
3. SEX female		4. RACE white		5. DATE OF BIRTH 5-2-1900		6. AGE (In years last birthday) 67 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Book Store	
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY Wash.		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First William H.		Middle Springer	Last	15. MOTHER'S MAIDEN NAME First Martha		Middle -	Last Swope
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 569-22-1108		17. INFORMANT Mr. John R. Alter Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia APPROXIMATE INTERVAL 485 X BETWEEN ONSET AND DEATH 24 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 497 X (b) Upper gastrointestinal bleeding DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinoma of heart of pancreas							
MEDICAL CERTIFICATION	19a. DATE OF OPERATION 1/5/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Jaundice		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) Not while at work	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1-28-68 , 19 68 , to 2-1-68 , 19 68 , that (I) (we) last saw the deceased alive on 2-1 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edson B. Moody</i>		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 363 S. Cleveland Ave. Hagerstown, Md.	
22d. PHYSICIAN'S NAME (Type) Dr. Edson B. Moody		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-3-68	23c. NAME OF CEMETERY OR CREMATORIAL Cedar Lawn Memorial Park		23d. LOCATION (City or Town) Hagerstown, Md.	(County) 	(State)
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	DATE FEB 5 1968	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

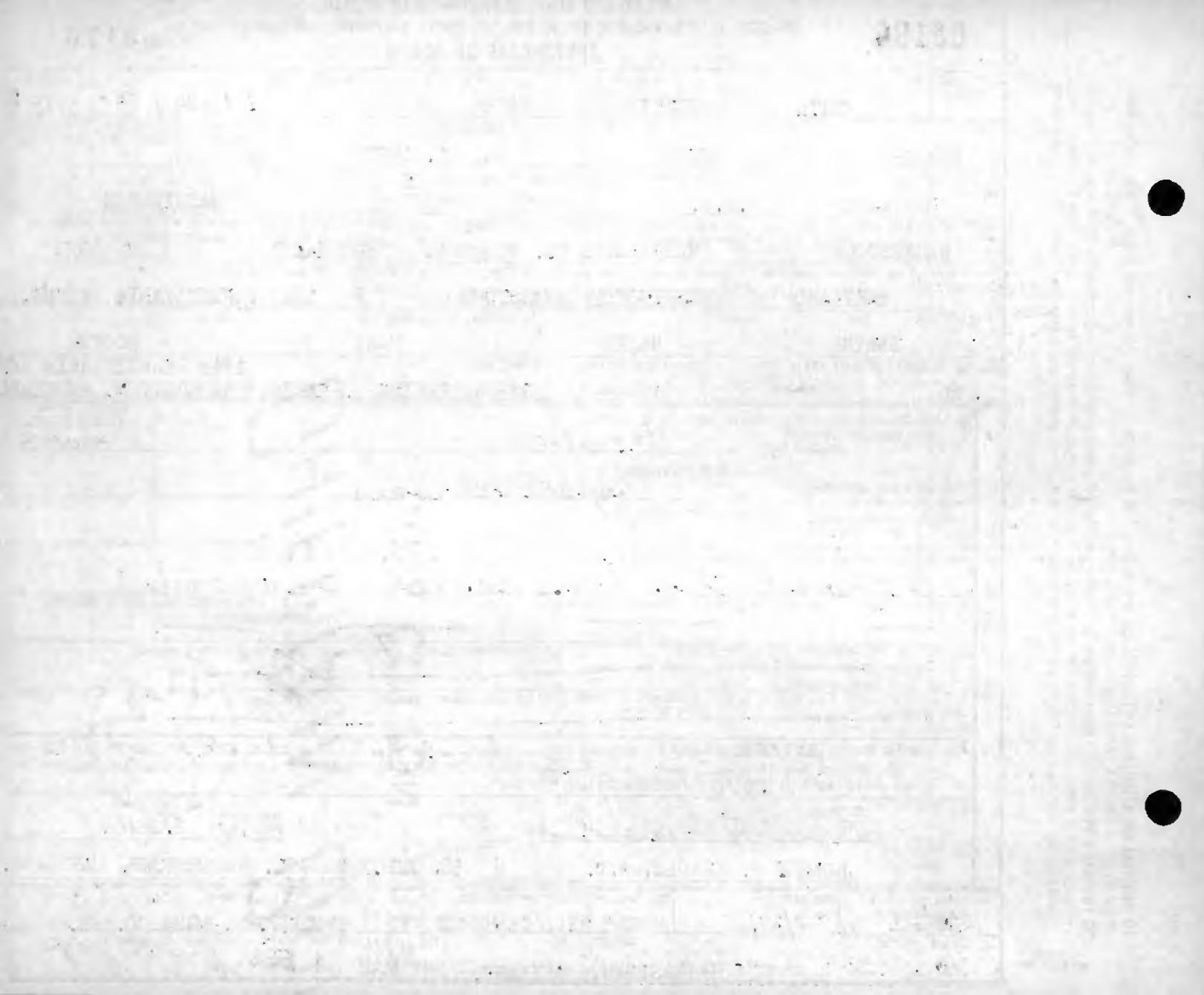
CERTIFICATE OF DEATH

03176

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 1 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First EDITH	Middle ELEVIN	Last BAKER	2a. DATE OF DEATH Month 2 / Day 24 / Year 68	2b. HOUR 5:15 P.M.
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MAY 31, 1877	6. AGE (In years last birthday) 90	IF UNDER 1 YEAR MONTHS YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1713 PENNSYLVANIA AVENUE,	
14. FATHER'S NAME DANIEL	First Middle BAKER	15. MOTHER'S MAIDEN NAME MARY	Middle HOOVER	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. ***	17. INFORMANT none	17a. PENNSYLVANIA AVE MISS CATHERINE G. BAKER, HAGERSTOWN, MARYLAND	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 WKS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic heart disease, pneumonia</u>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) <input checked="" type="checkbox"/> attended the deceased from <u>2-23-1968</u> to <u>death</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>2-24-1968</u> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
22b. SIGNATURE <u>Robert F. Keadle</u>	DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/26/68	
22d. PHYSICIAN'S NAME (Type) ROBERT F. KEADLE, M.D.	22e. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MARYLAND.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/27/68	23c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY	23d. LOCATION (City or Town) HAGERSTOWN, WASH CO. MD.	(County)	(State)
24. FUNERAL DIRECTOR <u>Charles M. Renger</u>	ADDRESS HAGERSTOWN, MARYLAND.	25a. REC'D BY REGISTRAR Date MAR 4 1968	25b. REGISTRAR'S SIGNATURE <u>Charles M. Renger</u>		



1 03195 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

93177

FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. file pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film G398 3 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First ARTHUR	Middle AYMORE	Lost BARGER	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 2	Day 24	Year 1968	2b. HOUR 7:00 M
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3. SEX MALE	4. RACE white	S. DATE OF BIRTH 6-4-1897	6. AGE (in years last birthday) 77 yrs.	IF UNDER 1 YEAR MONTHS 7	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0	2c. DATE PRONOUNCED DEAD Month 2	Day 24	Year 1968	2d. HOUR 7:00 M
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7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Washington
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10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 411 W. Washington St.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer	12b. KIND OF BUSINESS OR INDUSTRY railroad
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13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 411 W. Washington St.
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14. FATHER'S NAME First Geafulis	Middle Barger	Last 	15. MOTHER'S MAIDEN NAME First Mary E. Harrison	Middle 	Last
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16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 705-10-5562	17. INFORMANT Mrs. Louise Shaw, Hagerstown, Md.	ADDRESS
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral lobular pneumonia		3-5 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Malnutrition		3 yrs
(c) Ch. Alcoholism		10 yrs +

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
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19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
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21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
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22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
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ACTUAL SIGNATURE <i>Edward W. Ditto, III</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>
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EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.	M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 2-27-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
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24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 28 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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2
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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03196 03178

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 40 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash. Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sallie	Middle Elizabeth	Last Barger		
4. DATE OF DEATH Feb. 18 1968	Month Feb.	Day 18	Year 1968		
5. SEX Female	6. COLOR DR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1889		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS DR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Weisport Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. 384-24-11224	17. INFORMANT Mrs. Ruth Carpenter	Address RD2 Clear Spring			
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 4200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4200					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 10/26 5 21/8 68	20f. (City or town) Hagerstown	(County) Md.	(State) Md.
21. I certify that (I) (this hospital) attended the deceased from 10/26 5 21/8 68, 1968, to 10/26 5 21/8 68, 1968, that (II) (we) last saw the deceased alive on 10/26 5 21/8 68, 1968, and that death occurred at 10/26 5 21/8 68, 1968, M, from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Donald E. Martin	22b. DATE SIGNED 2/19/68				
22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.	22d. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 21, 68	23c. NAME OF CEMETERY OR CREMATORIUM Cedar Lawn Memorial Park	23d. LOCATION (City, town or county) Hagerstown	(State) Md.	
24. FUNERAL DIRECTOR Donald E. Thompson	ADDRESS Thompson Funeral Home Clear Spring, Md.	25a. REC'D BY REGISTRAR FEB 20 1968	25b. REGISTRAR'S SIGNATURE Charles J. Jager		

MARYLAND STATE DEPARTMENT OF HEALTH

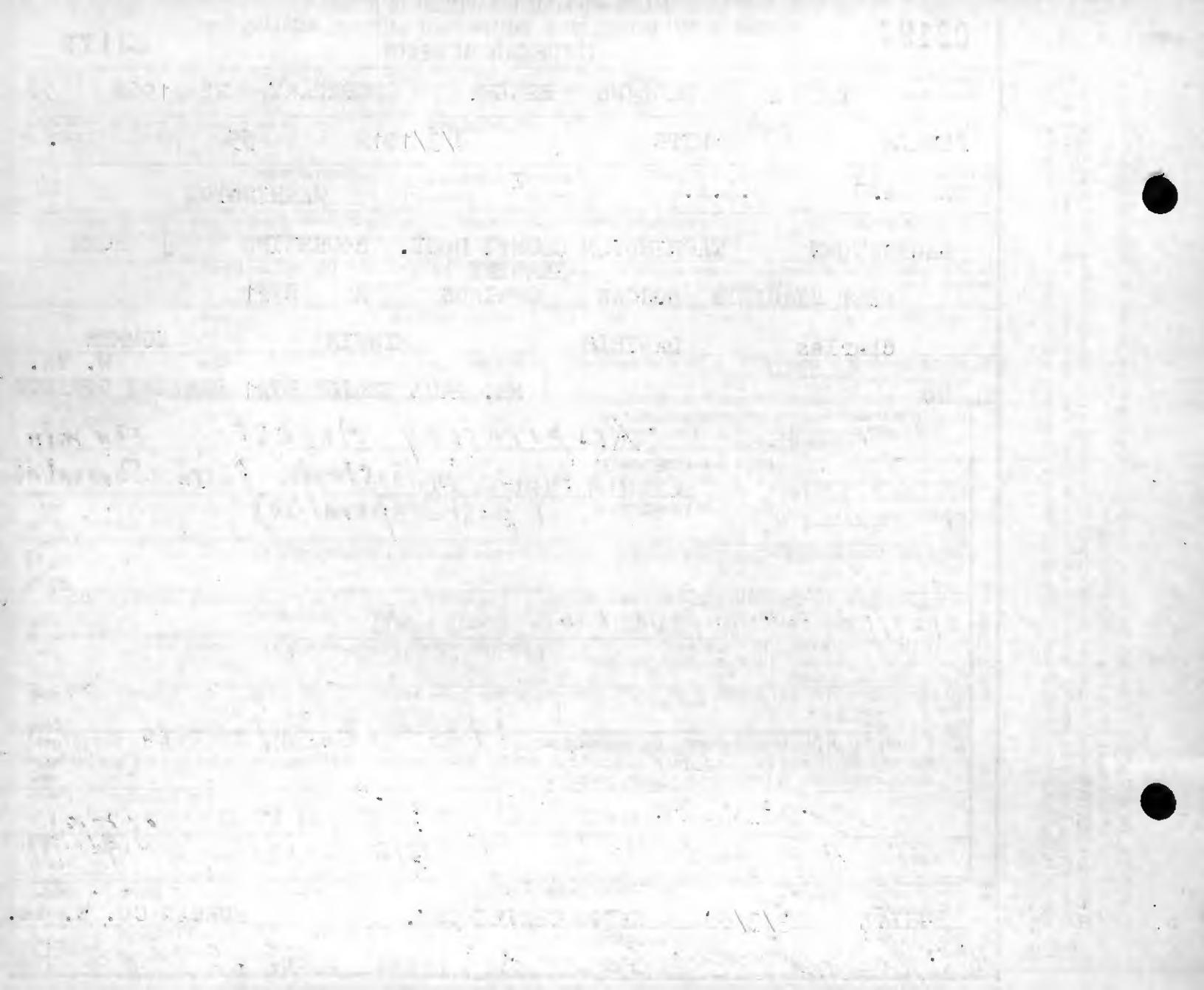
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)	First THELMA	Middle PAULINE	Last BEELER	2a. DATE OF DEATH FEBRUARY Month 28 Day 1968	2b. HOUR 5P M
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 8/3/1912	6. AGE (in years last birthday) 75	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPE	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE WEST VIRGINIA	13b. COUNTY MORGAN	13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RT#1		
14. FATHER'S NAME Charles	First Midde DANIELS	15. MOTHER'S MAIDEN NAME MINNIE	Middle Last YOMMER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO.	17. INFORMANT MR. PAUL BEELER RT#1 BERKLEY SPRINGS	Address W. VA. BERKLEY SPRINGS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2381</u> Respiratory Arrest. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few min. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain tumor in posterior fossa Several Mo. DUE TO, OR AS A CONSEQUENCE OF (c) (post-operative)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 237X					
MEDICAL CERTIFICATION	19a. DATE OF OPERATION 2/27/68	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Posterior fossa tumor	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25/68</u> to <u>2/28/69</u> , that (I) (we) last saw the deceased alive on <u>2/28/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>A. F. Abdullah</u>	19. DEGREE ATTENDING PHYS.	22c. DATE SIGNED 2/29/68			
22d. PHYSICIAN'S NAME (Type) A. F. Abdullah	22e. ADDRESS 318 N. Potomac, Hagerstown Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/3/68	23c. NAME OF CEMETERY OR CREMATORIUM UNION CHAPEL CEM.	23d. LOCATION (City or Town) MORGAN CO. W. VA.	(County)	(State)
24. FUNERAL DIRECTOR W. J. Horowitz, Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR DAT MAR 1 1968	25b. REGISTRAR'S SIGNATURE Charles Justice		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First Margaret	Middle Broom	Last Bell	2a. DATE OF DEATH Month Feb Day 26 Year 1968	2b. HOUR M
3. SEX Female		4. RACE Colored	5. DATE OF BIRTH Oct 8 1887		6. AGE (In years last birthday) 80 yrs.	
7a. BIRTHPLACE (State or foreign country) Hagerstown Md.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Boonsboro, Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Reeders Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR IND.STRY Own home
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? Hagerstown YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 222 N Jonathan St	
14. FATHER'S NAME Unknown		15. MOTHER'S MAIDEN NAME Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Margaret Washington		Address 134 W. North St., Hagerstown Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Methasalolite cardio vascular disease				APPROXIMATE NUMBER BETWEEN ONSET AND DEATH 10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
(b)		DUE TO, OR AS A CONSEQUENCE OF				
(c)		DUE TO, OR AS A CONSEQUENCE OF				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION MEDICAL CERTIFICATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 10</u> , 1967, to <u>Feb 26</u> , 1968, that (I) (we) last saw the deceased alive on <u>Feb 13</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>G. W. Bellan MD</i>		22c. DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22d. DATE SIGNED <i>Feb 29, 1968</i>	
22d. PHYSICIAN'S NAME (Type) <i>G. W. Bellan</i>		22e. ADDRESS <i>Boonsboro, Md.</i>				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-2-1968	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown Md.	(County) (State)
24. FUNERAL DIRECTOR <i>John R Watson Jr. Hagerstown Md.</i>		ADDRESS <i>John R Watson Jr. Hagerstown Md.</i>	25a. REC'D BY REGISTRAR MAR 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)		First EMMA	Middle LENORA	Lost BENNER	2a. DATE OF DEATH Month 2	Day 27	Year 1968	2b. HOUR 10:55	
3. SEX		4 RACE WHITE		5. DATE OF BIRTH MARCH 27, 1879		6. AGE (In years last birthday) 88 YRS.			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 814 POTOMAC AVENUE		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) PRESIDENT		12b. KIND OF BUSINESS OR INDUSTRY SUPPLIES INDUSTRIAL			
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 68 EAST AVENUE,		
14. FATHER'S NAME First HENRY		Middle C.	Lost FOLTZ	15. MOTHER'S MAIDEN NAME First ANNIE		Middle MILLER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 218-30-9648		17. INFORMANT MRS. GRACE E. PLACK,		1814 POTOMAC AVENUE, HAGERSTOWN, MARYLAND.			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART 1. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Cerebral thrombosis 4339 DUE TO, OR AS A CONSEQUENCE OF Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> <p>(b) Cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yr.</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>19. MEDICAL CERTIFICATION</p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (have) attended the deceased from March 7, 1966 to Feb. 27, 1968 , that (I) (have) last seen the deceased alive on 2/26/68 at 19 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input type="checkbox"/> (did not) view the body after death.									
22b. SIGNATURE B. B. Kneisley		22c. DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/28/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 148 W. WASHINGTON ST. HAGERSTOWN, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/29/68		23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY		23d. LOCATION (City or Town) HAGERSTOWN, WASH. CO. MD.		(County) (State)	
24. FUNERAL DIRECTOR Nelson L. Eichelberger		25a. ADDRESS Rouzer Funeral Home		25b. REC'D. BY REGISTRAR MAR 4 1968		25b. REGISTRAR'S SIGNATURE James J. Sager			
VR A15 (4) 30M REV 1/68				DATE					



33200

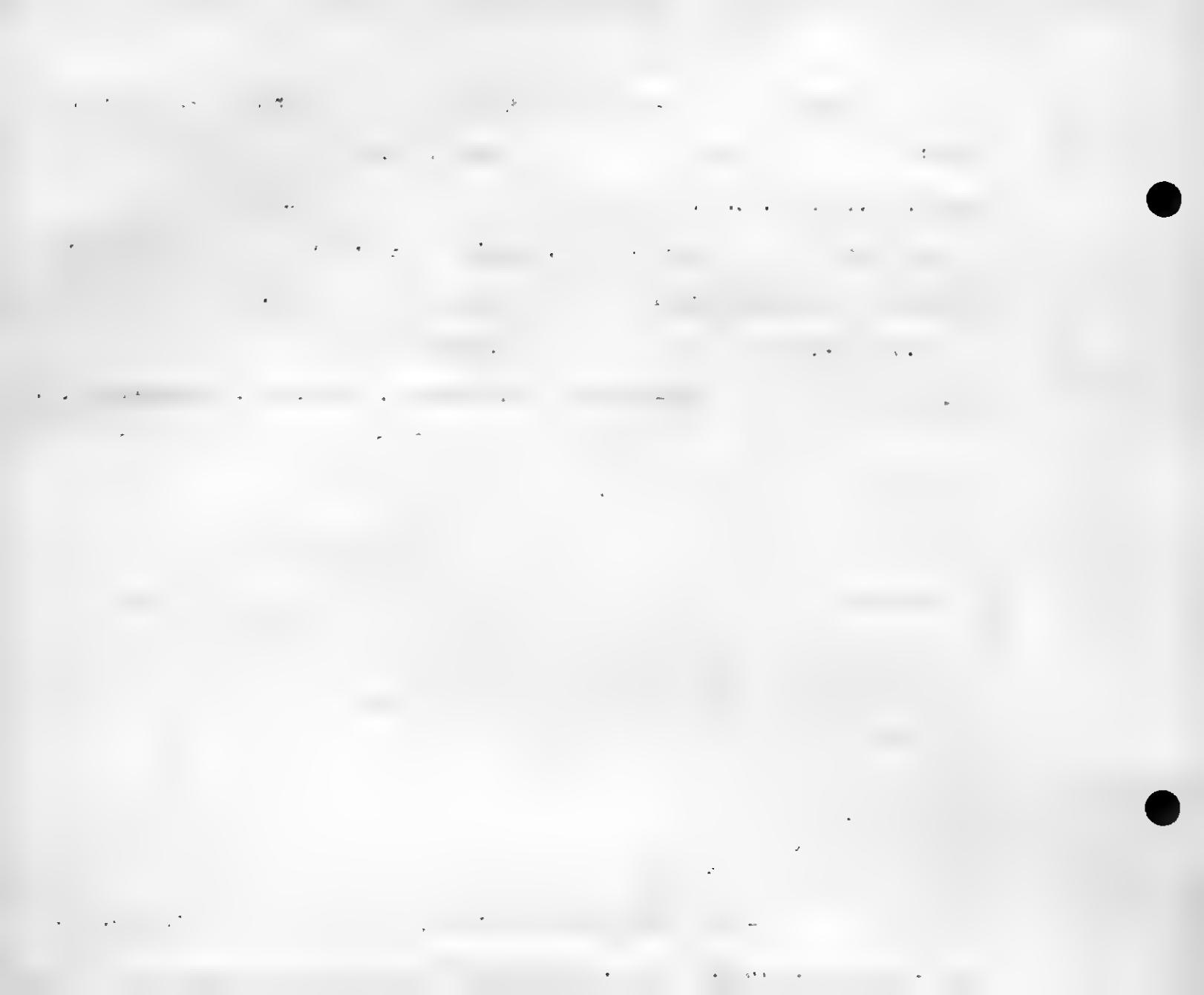
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

2182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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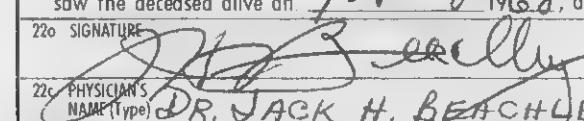
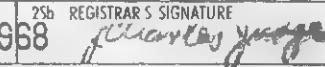
1. DECEASED-NAME (Type or print)				First Carrie	Middle Mae	Last Betts	2a. DATE OF DEATH Month February	Day 9	Year 1968	2b. HOUR :00 P.M.							
3. SEX Female		4 RACE White			5. DATE OF BIRTH July 1, 1898		6. AGE (In years last birthday) 69		7. IF UNDER 24 HRS MONTHS 7		8. IF UNDER 1 YEAR DAYS 8		9. IF UNDER 24 HRS HOURS 0				
7a. BIRTHPLACE (State or foreign country) Carroll Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Washington										
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington			13c. CITY OR TOWN Boonsboro		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER Rfd. 2								
14. FATHER'S NAME First Albert Warner		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Caroline Evans		Middle 	Last 										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.		16b. SOCIAL SECURITY NO 219-20-3313			17. INFORMANT Mr. Arbrey S. Betts, Rfd. 2 Boonsboro, Md.		Address										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7-31-4		Cerebral Hemorrhage					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days										
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> 7-31-4		DUE TO, OR AS A CONSEQUENCE OF (b) Severe (5 an days) an days					Year										
DUE TO, OR AS A CONSEQUENCE OF (c) 																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 21-1																	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)												
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State						
22a. I certify that (I) (this hospital) attended the deceased from 3-23 , 1967, to 2-9- , 1968, that (I) (we) last saw the deceased alive on 2-9- , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE John H. Bast, Jr.		22c. DEGREE ATTENDING PHYS.			22d. MED. DIRECTOR			22e. STAFF PHYS.		DATE SIGNED 2-10-68							
22d. PHYSICIAN'S NAME (Type) JOSEPH SECUNDARI		22e. ADDRESS Boonsboro Md															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-12-68		23c. NAME OF CEMETERY OR CREMATORIUM Beaver Creek Cemetery			23d. LOCATION (City or Town) Beaver Creek Wash Co. Md.		(County)		(State)						
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS			25a. REC'D. BY REGISTRAR FEU 14 10			25b. REGISTRAR'S SIGNATURE									
VR A15 (4) 30M REV. 1/68																	

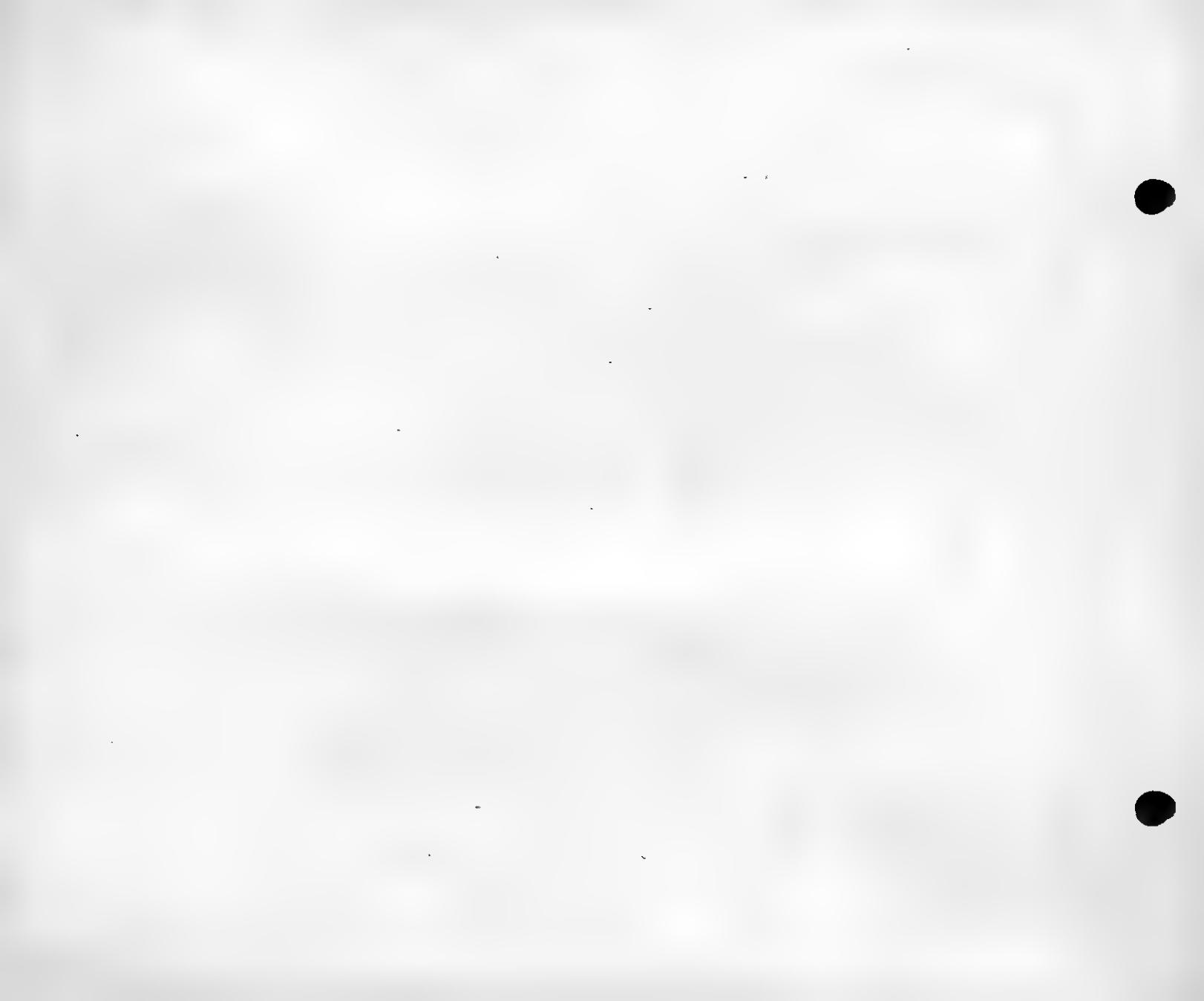


MARYLAND STATE DEPARTMENT OF HEALTH
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CERTIFICATE OF DEATH		33183	
<p>1. PLACE OF DEATH a. COUNTY Washington MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport</p> <p>c. LENGTH OF STAY IN 1b —</p> <p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home</p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin</p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle</p> <p>d. STREET ADDRESS Greencastle, Pa.</p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED First EMMA Middle K. Last BITNER</p> <p>4. DATE OF DEATH Month February Day 28 Year 1968</p> <p>5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> <p>8. DATE OF BIRTH 10/29/1883 9. AGE (in years lost birthday) 84 yrs. 10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0</p>			
<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p> <p>11b. KIND OF BUSINESS OR INDUSTRY Home</p>		<p>11. BIRTHPLACE (County & State, or foreign country) Williamson, Pa.</p> <p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Jacob W. Hege</p>		<p>14. MOTHER'S MAIDEN NAME Mary Kriner</p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No</p>		<p>16. SOCIAL SECURITY NO. 162-10-4143 17. INFORMANT J. Nevin Bitner - Greencastle, Penna. Address</p>	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Dystaction? DUE TO i/o.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Kidney (b) — DUE TO — (c) —</p>		<p>INTERVAL BETWEEN ONSET AND DEATH 1 Day</p>	
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Carcinoma of Transverse Colon. Pyelitis. Obesity</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. — p.m. 19</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> of work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —</p> <p>20f. (City or town) — (County) — (State) —</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from 10/28/68 to 10/28/68, that (I) (we) last saw the deceased alive on 10/28/68, and that death occurred at 4:45 P.M. from causes and on the date stated above.</p>			
<p>22a. SIGNATURE </p>		<p>22b. DATE SIGNED 3/1/68</p>	
<p>22c. PHYSICIAN'S NAME (Type) DR. JACK H. BEACHLEY</p>		<p>22d. ADDRESS HAGERSTOWN, M.D.</p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) Burial</p>		<p>23b. DATE THEREOF 3/2/68 23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.</p>	
<p>24. FUNERAL DIRECTOR A.E. Minnick - Greencastle, Pa.</p>		<p>25a. REC'D BY REGISTRAR ADDRESS — DATE MAR 5 1968 25b. REGISTRAR'S SIGNATURE </p>	



MARYLAND STATE DEPARTMENT OF HEALTH
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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)			First OLIVER	Middle FRANCIS	Last BOWLING	2a. DATE OF DEATH Month Feb. Day 26 Year 68	2b. HOUR 1:59PM
3. SEX Male		4. RACE White	5. DATE OF BIRTH Dec. 31, 1905			6. AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 M/M
7a. BIRTHPLACE (State or foreign country) Adams Co. Pa.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington County	
10. CITY OR TOWN OF DEATH Hagerstown,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Furniture Finisher		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 607 S. Potomac Street
14. FATHER'S NAME First John		Middle Bowling	15. MOTHER'S MAIDEN NAME First Alice			Middle McCleaf	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 176-07-9698		17. INFORMANT Mrs. Oliver F. Bowling, 607 S. Potomac St.		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>/cavicular Embolations</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i> <i>410.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any (which gave rise to immediate cause (a), stating the underlying cause last.) <i>Coronary Occlusion</i> (b) <i>Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes Mellitus</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>.../</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.			City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from 2/5/68, 1968, to 2/26, 1968, that (I) (we) last saw the deceased alive on 2/26/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert V.H. Campbell</i>		DEGREE ATTENDING PHYS.	22c. DATE SIGNED 2/27/68				
22d. PHYSICIAN'S NAME (Type) Robert V.H. Campbell		22e. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 29, 1968	23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Catholic			23d. LOCATION (City or Town) (County) (State) Fairfield, Adams Co. Pa.	
24. FUNERAL DIRECTOR <i>Clarence E. Wilson</i>		ADDRESS Emmitsburg, Md.			25a. REC'D BY REGISTRAR DATE MAR 1 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



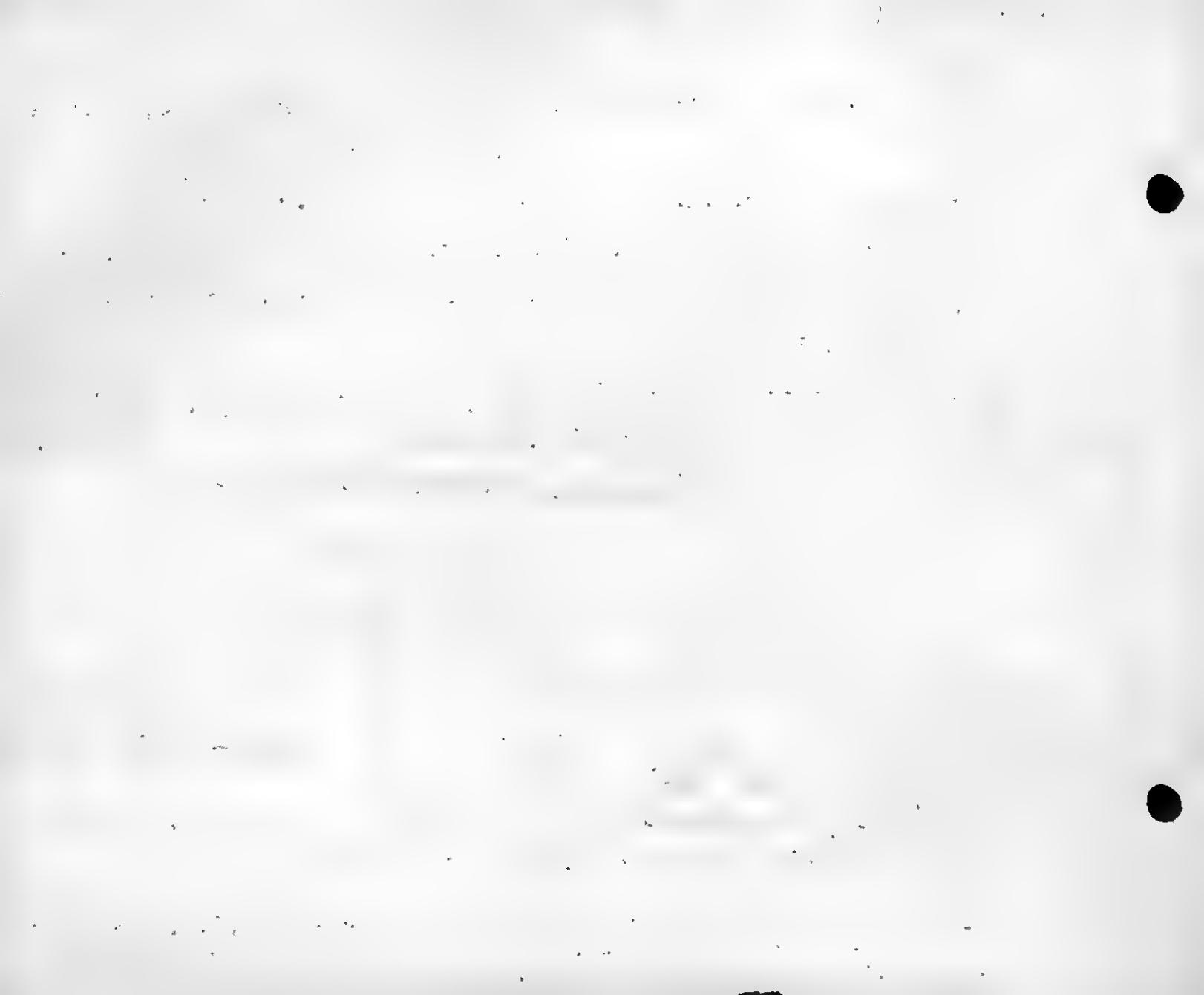
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CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH	Month	Day	Year	2b HOUR		
William Statton Bowman						February	12	1968	7 A M			
3 SEX	4 RACE				S. DATE OF BIRTH	6. AGE (in years from last birthday)		IF UNDER MONTHS				
Male	White				Aug 11 1874	93	YRS.	IF UNDER 24 HRS	MONTHS	IF UNDER 24 HRS		
						7. BIRTHPLACE (State or foreign country)	8. CITIZEN OF WHAT COUNTRY?		9. COUNTY OF DEATH			
Maryland			U.S.A.	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Hagerstown,		36 South Cannon Ave			Farmer			Retired				
13a. USUAL RESIDENCE (Where deceased admission) STATE		lived, if institution. Residence before		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/>	NO <input type="checkbox"/>	13e STREET AND NUMBER				
Maryland		Washington		Hagerstown				36 S. Cannon Ave.				
14 FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last			
David E. Bowman					Susan Rowe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address						
No		218-30-9806		Mrs Pauline P. Fields		Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											between onset and death Nov. 10-1968	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension Cardi-Vascular D.</u>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
441X		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 13</u> , 1968, to <u>Feb 12</u> , 1968, that (I) (we) last saw the deceased alive on <u>Feb 12</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Sidney Novenstein</u>		DEGREE	ATTENDING PHYS	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>2/12/68</u>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		FUNKSTOWN MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/14/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Funkstown Cemetery		23d. LOCATION (City or Town) Funkstown		(County)	(State)			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		Hagerstown, Maryland.				25a. RECD BY REGISTRAR FEB 15 1968		25b. REGISTRAR'S SIGNATURE Funkstown, Washington, Md.				

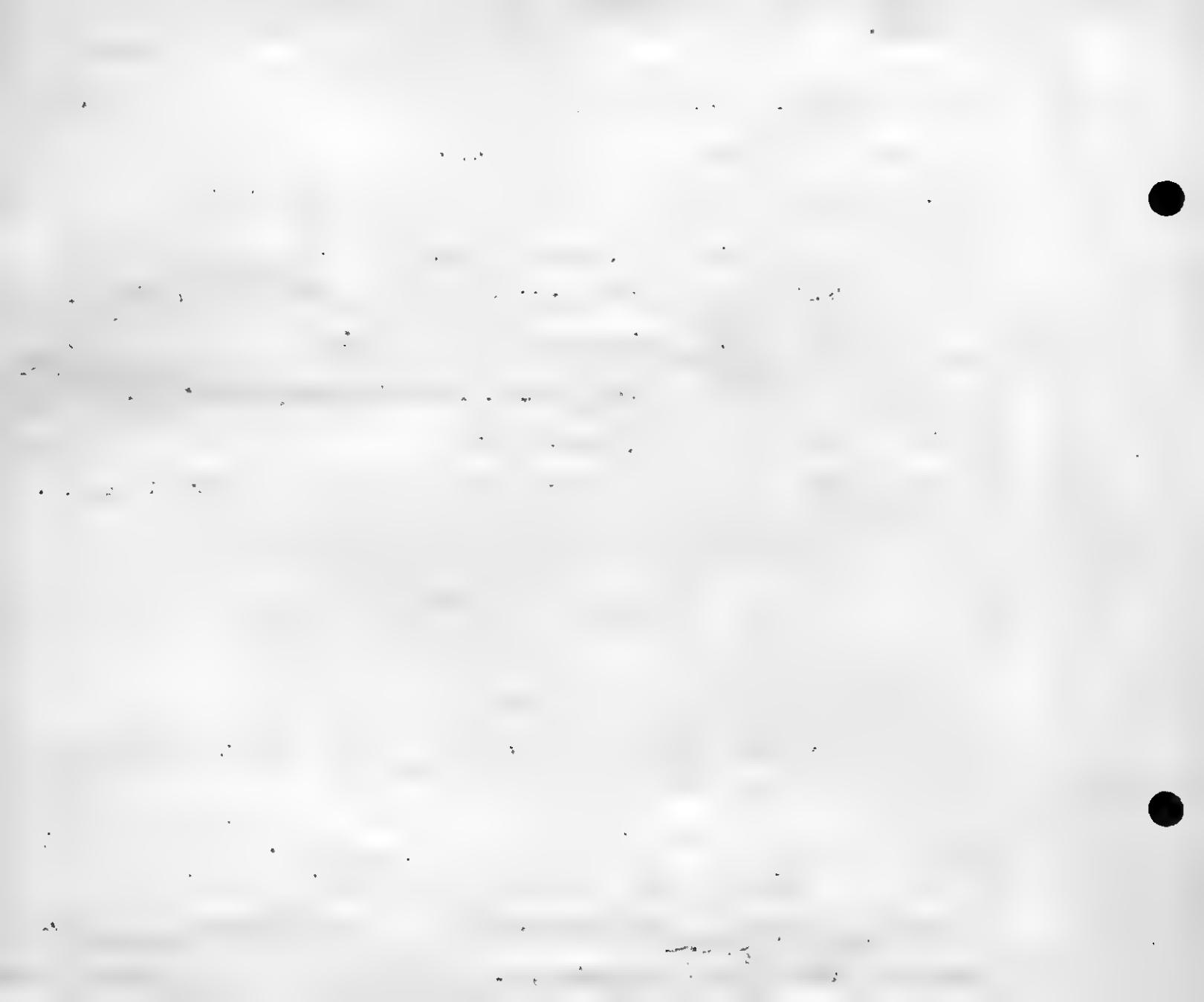


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> , Year <u>1968</u>	2b. HOUR <u>9:15</u> M
3. SEX <u>M</u>	4. RACE <u>W</u>	5. DATE OF BIRTH <u>1/16/60</u>		6. AGE (in years last birthday) <u>8</u> YRS.	IF UNDER MONTHS YEAR DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <u>WASHINGTON</u>		
10. CITY OR TOWN OF DEATH <u>HAGERSTOWN</u>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) <u>WESTERN MD. STATE HOSPITAL</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>None</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>
13a. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE <u>maryland</u>	13b. COUNTY <u>washington</u>	13c. CITY OR TOWN <u>Hagerstown</u>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <u>2207 Pennsylvania Ave.</u>	
14. FATHER'S NAME First <u>William</u>	Middle <u>EVANS</u>	Last <u>Boyes</u>	15. MOTHER'S Maiden Name First <u>Reine</u>	Middle <u>Schultz</u>	Last <u>3 days</u>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <u>None</u>	Address <u>Hagerstown, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobular pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Neuronal Degeneration of Brain</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1/2 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DUE CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. <u>10</u> Month <u>Aug.</u> Day <u>1</u> Year <u>1968</u>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.) <u>19</u>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. <u>2207</u>	City or Town <u>Hagerstown</u>	County <u>Washington</u>	State <u>Md.</u>
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1, 1968</u> to <u>Feb. 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Victor L. Ramos, M.D.</u>			22c. DATE SIGNED <u>Feb. 17, 1968</u>		
22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS <u>Western Maryland State Hospital</u> <u>Hagerstown, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/20/68</u>	23c. NAME OF CEMETERY OR CREMATORIUM <u>Edge Hill Cemetery</u>	23d. LOCATION (City or Town) <u>West Nanticoke</u>	(County) <u>Pa.</u>	(State)
24. FUNERAL DIRECTOR <u>W.L. Ramos</u>	ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>	25a. REC'D. BY REGISTRAR <u>FEB 21 1968</u>	25b. REGISTRAR'S SIGNATURE <u>Victor L. Ramos</u>		



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03187

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First PRESTON	Middle ARTHUR	Last BRITNER JR	2a. DATE OF DEATH Month 24	Year 68	2b. HOUR M
3. SEX M	4. RACE W	5. DATE OF BIRTH JULY 7 1901		6. AGE (In years last birthday) 68	IF UNDER 1 YEAR MONTHS	F. UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) PITTSBURG PENNA. U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON MD.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) COMPTROLLER		12b. KIND OF BUSINESS OR INDUSTRY AIR CRAFT
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 106 STUART DR. MT. TAMMEY	
14. FATHER'S NAME PRESTON A BRITNER SR.		15. MOTHER'S MAIDEN NAME MINNIE DAUGHERTY				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO.		17. INFORMANT ELIZABETH F BRITNER 106 STUART DR.		Address MT. TAMMEY MD.
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 48UX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Acute pyelonephritis Pneumonia, viral		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days 3 wks -
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Coronary heart disease, cerebral thrombosis						
19c. MEDICAL CERTIFICATION	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from _____, to _____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>John H. Hornbaker, M.D.</i>	DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2-26-68	
22d. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.	22e. ADDRESS 154 West Washington St., Hagerstown, Md. 21740					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2.28.68	23c. NAME OF CEMETERY OR CREMATORIUM GREEN LAWN	23d. LOCATION (City or Town) WILLIAMSPORT	(County) WASHINGTON	(State) MD.	
24. FUNERAL DIRECTOR <i>Howard J. Hornbaker, M.D.</i>	ADDRESS 154 West Washington St., Hagerstown, Md. 21740	25a. REC'D BY REGISTRAR DATE FEB 29 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Young</i>			

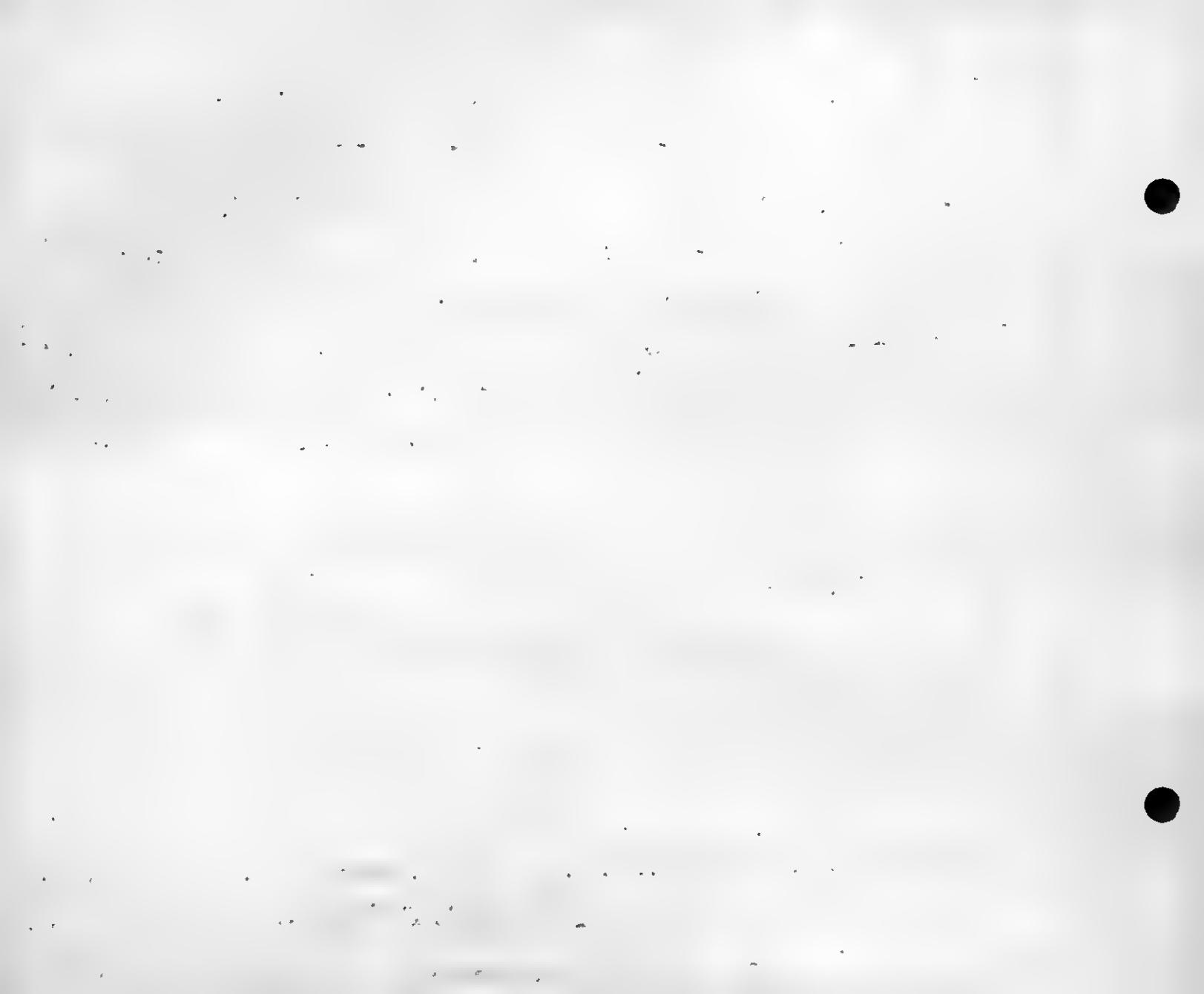


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First <i>Ira</i>	Middle <i>A.</i>	Lost <i>Brown</i>	2a. DATE OF DEATH 2 Month 25 Day 68 Year	2b. HOUR 7:45 AM		
3. SEX <i>male</i>		4. RACE <i>white</i>	5. DATE OF BIRTH <i>Aug. 14 1883</i>		6. AGE (In years lost birthday) <i>84 yrs.</i>	7. IF JUNIOR 1 YEAR MONTHS <i>6</i>	8. IF JUNIOR 24 HRS DAYS <i>11</i>	
7a. BIRTHPLACE (State or foreign country) <i>Fredericks</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Washington Co.</i>			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Wash. Co. Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Farmer</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Cullen State Hosp</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md.</i>		13b. COUNTY <i>Frederick Suburbia</i>	13c. CITY OR TOWN <i>Frederick Suburbia</i>	13d. INSIDE CITY, J.M. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>111</i>			
14. FATHER'S NAME First <i>Theodore</i>		Middle <i>Brown</i>	15. MOTHER'S MAIDEN NAME First <i>Hesta</i>		Middle <i>Himes</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Mayda McCoy - Hanesboro</i>	Address <i>111</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobular pneumonia</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease, coronary sclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last</i>		DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic heart disease, coronary sclerosis</i>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No <i>145 W. Washington St.</i>	City or Town <i>Hagerstown, Md.</i>	County <i>Frederick</i>	State <i>Md.</i>	
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 4, 1968</i> , to <i>Feb 25, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb. 20, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>L. L. Packer, Jr., M. D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>2/26/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>L. L. Packer, Jr., M. D.</i>		22e. ADDRESS <i>145 W. Washington St., Hagerstown, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3-28-68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Sabillasville Church</i>		23d. LOCATION (City or Town) (County) (State) <i>Sabillasville-Fred. Md.</i>			
24. FUNERAL DIRECTOR <i>Creager Funeral Home - Thurmont</i>		ADDRESS <i>Creager Funeral Home - Thurmont</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

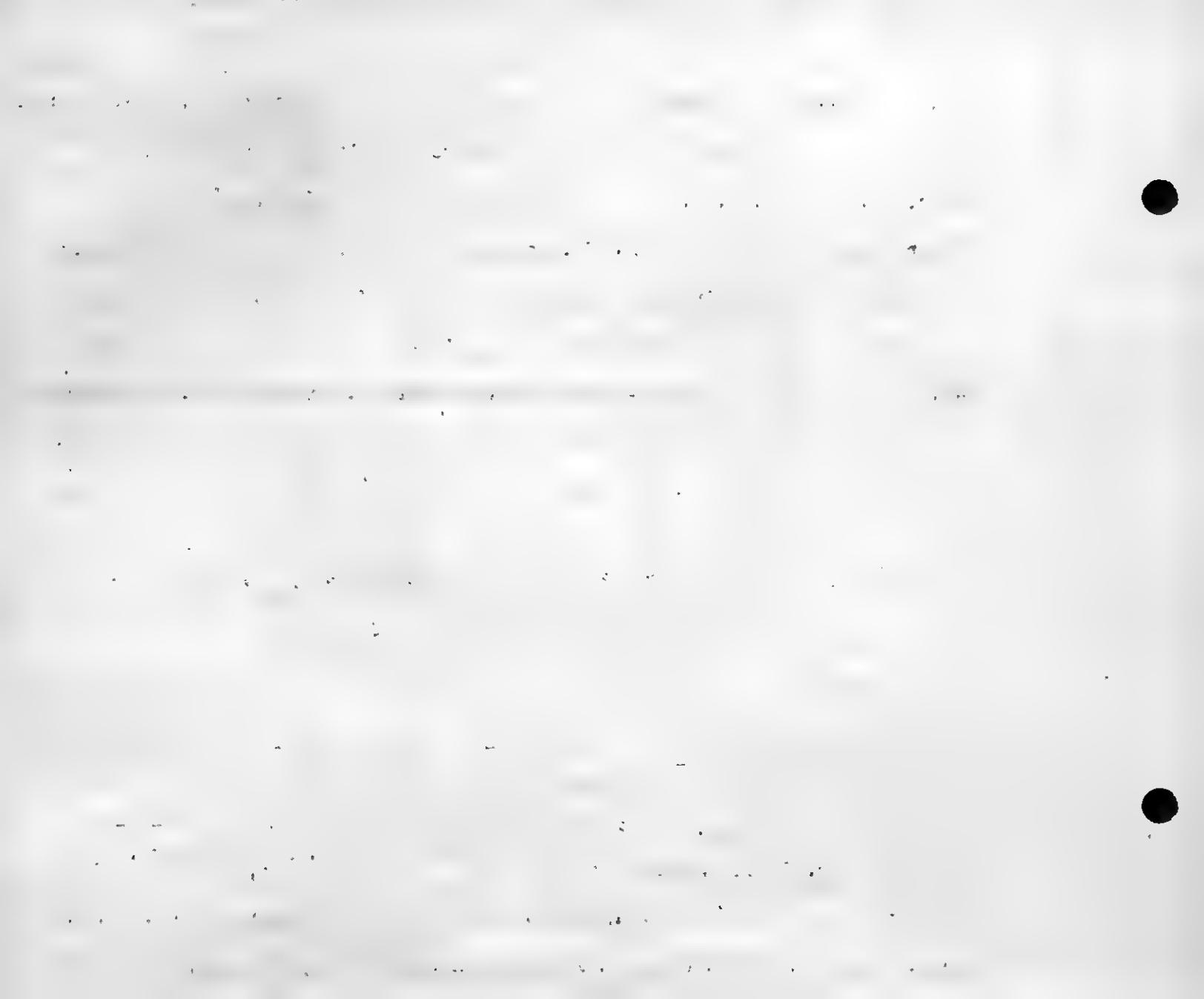


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)	First Jacob	Middle Harp	Last Burtner	20. DATE OF DEATH Month February 15, 1968	2b. HOUR 6:30P.M.					
3. SEX Male	4. RACE White	5. DATE OF BIRTH November 1, 1878		6. AGE (In years last birthday) 89	IF UNDER 1 YEAR MONTHS 3	IF UNDER 24 HRS. DAYS 14	HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Manor, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington							
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER Rfd. 1						
14. FATHER'S NAME First Ezra	Middle Burtner	Last Sarah	15. MOTHER'S MAIDEN NAME First Harp							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO 211-36-2469	17. INFORMANT Miss Rose Mary J. Burtner, Rfd. 1, Boonsboro	Address Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks				
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause arteriosclerotic heart disease, pulmonary embolism						many years				
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease, pulmonary embolism										
DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease, pulmonary embolism										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) arteriosclerotic heart disease, pulmonary embolism										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from 2-13, 1968 , to 2-16, 1968 , that (I) (we) last saw the deceased alive on 2-16-68 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Edson B. Moody	EDUCATIONAL DEGREE EDUCATION	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2-16-68					
22d. PHYSICIAN'S NAME (Type) Dr. Edson B. Moody	22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Maryland 21740									
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 2-18-68	23c. NAME OF CEMETERY OR CREMATORIUM Boonsboro Cemetery	23d. LOCATION (City or Town) Boonsboro, Wash. Co., Md.	(County) Boonsboro, Wash. Co., Md.	(State) Boonsboro, Wash. Co., Md.					
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	ADDRESS		25a. RECD BY REGISTRAR CHARLES JUDGE	25b. REGISTRAR'S SIGNATURE CHARLES JUDGE						
DATE Feb 20 1968										



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1 DECEASED NAME (Type or print)		First	Middle	Lost	2a DATE OF DEATH Month	Doy	Year	2b HOUR 2:00 P.M.					
Myrtle May Carson					Feb.	18	1968						
3 SEX F		4. RACE W		5. DATE OF BIRTH Jan. 7, 1892		6. AGE (In years lost birthday) 76 YRS.		7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS. DAYS	9. IF UNDER 24 HRS. HOURS	10. IF UNDER 24 HRS. MIN.		
7a BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON							
10. CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Clerk		12b KIND OF BUSINESS OR INDUSTRY Printing Co.							
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 232 N. Locust Street							
14. FATHER'S NAME First LEWIS		Middle Maugans	Lost	15 MOTHER'S MAIDEN NAME First Mary Elizabeth Cromer		Middle	Lost						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 220-28-8964		17 INFORMANT Mrs. Doris Harclerode		Address Hagerstown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) confluent lobar pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 40 days (b) Lung abscess, Right upper lobe DUE TO, OR AS A CONSEQUENCE OF (c) hypertension v.e. Heart Disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one week 1st 3 months unknown one year					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Rheumatoid arthritis								36 years					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No.		City or Town		County		State			
22a. I certify that (I) (not present) attended the deceased from NOV. 27, 1967 , to Feb. 18, 1968 , that (I) (not) last saw the deceased alive on Feb. 18, 1968 , and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above, (I) (not) (did) (not) view the body after death.													
22b. SIGNATURE FE U. Porcupine		DEGREE Attending Phys.	ATTENDING PHYS. <input type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 2/19/68							
22d. PHYSICIAN'S NAME (Type) FE U. ORCUNCULA		22e. ADDRESS Western Md. State Hospital Hagerstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-21-68		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown, Md.		(County)		(State)			
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 21 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge							



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give copies to F. 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 2 and 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

Item 2a File # 6708
3/1/68 kk 209 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR	
ELIZABETH REBECCA CLOWES						2	24	168	10:30 PM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS						
FEMALE	WHITE	2/24/1883	85 yrs.								
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MARYLAND		U.S.A.				WASHINGTON			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			424 SOUTH POTOMAC ST.			CLERK			GROCERY STORE		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
MARYLAND			WASHINGTON HAGERSTOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			424 SOUTH POTOMAC STREET.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
OTHO W. CLOWES						ELEANORA					BAKER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS		
NO			214-09-6984			MRS. AMELIA KNAIPPER,			424 SOUTH POTOMAC ST. HAGERSTOWN, MARYLAND.		
18. CAUSE OF DEATH (Enter on a line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			Bilateral Colobomas prenunciatio						5 days		
(b)			Basal Cell Carcinoma Pt. Shoulder			DUE TO, OR AS A CONSEQUENCE OF			4-5 yrs		
(c)			C. ulcerans & Secondary Acanthia								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
19c. MEDICAL CERTIFICATION									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town	County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EDWARD W. DITTO, III, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			22b. DATE SIGNED 2/26/68		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			217 W. WASHINGTON ST. HAGERSTOWN, MARYLAND.		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE 2/26/68			23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.		
BURIAL						ADDRESS			25a. REC'D. BY REGISTRAR FEB 27 1968		
24. FUNERAL DIRECTOR									25b. REGISTRAR'S SIGNATURE J. L. Jones		
Chesapeake											
HAGERSTOWN, MARYLAND.											



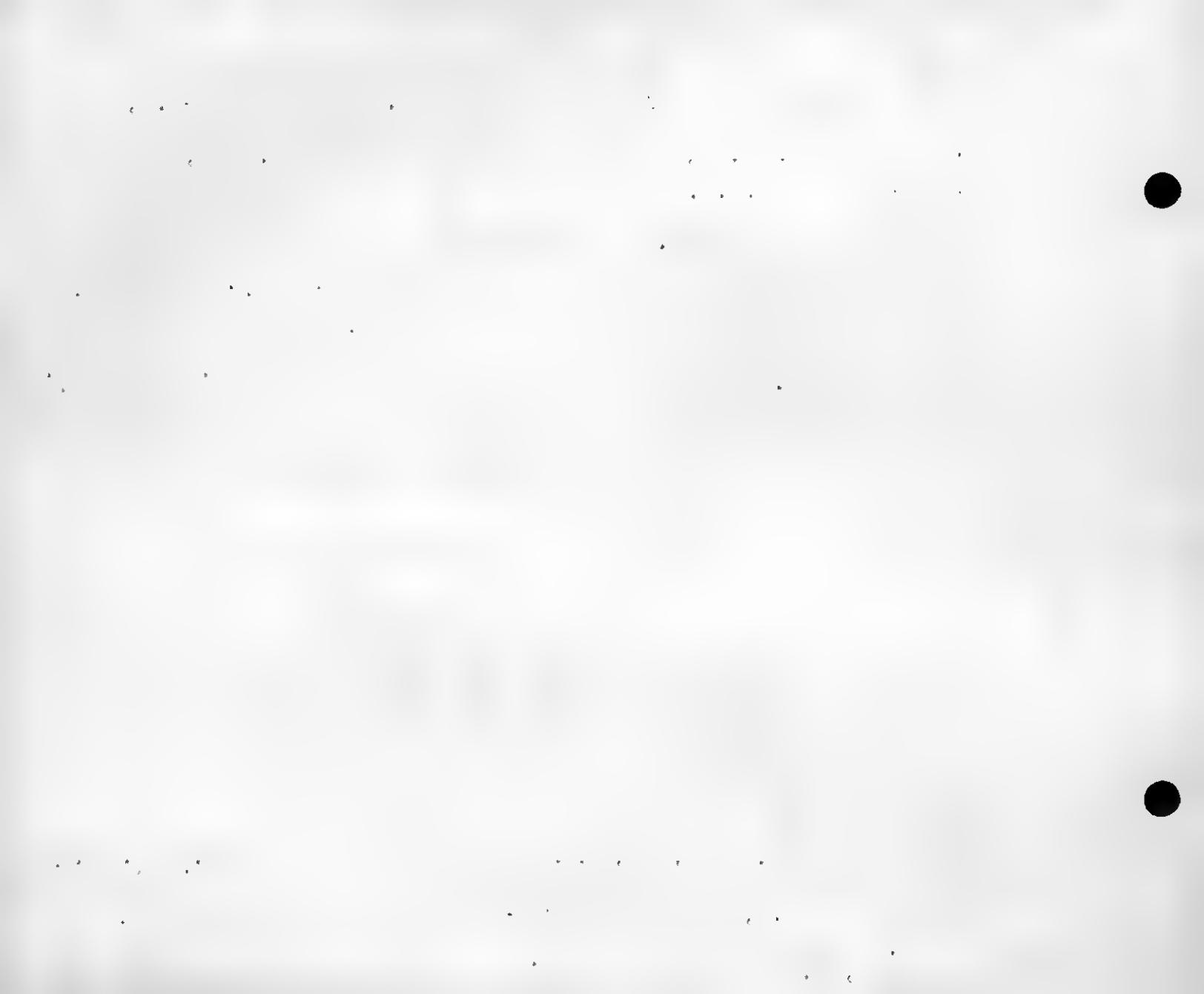
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)		First Charles	Middle William	LAST Cosey Sr.	20 DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> Feb. 5, 1968 20b HOUR M		
3 SEX Male	4 RACE White	5 DATE OF BIRTH Dec. 13, 1920	6 AGE (In years last birthday) 47 yrs	7 IF UNDER 1 YEAR MONTHS 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	IF UNDER 24 HRS DAYS HOURS MIN.	2c DATE PRONOUNCED DEAD Month Day Year Feb. 5, 1968 2d HOUR M	
7a B.RTHPL.ACE (State or foreign country) Washington		7b CIT ZEN OF WHAT COUNTRY? U.S.A.		9 COUNTY OF DEATH Washington			
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital 9a Street address) Washington County Hospital		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Machine Operator		12b KIND OF BUSINESS OR INDUSTRY Concrete Bl	
13a. US.JA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 125 N. Prospect St.		
14 FATHER'S NAME William Cosey		15 MOTHER'S MAIDEN NAME Pearl Rohrer					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) Yes		16b SOCIAL SECURITY NO 777-3		17 INFORMANT 20 ADDRESS 217-09-9717 Mrs Helen L, Cosey Williamsport, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3057 (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause b) stating the underlying cause c)		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Aspiration Belching Gastric contents Alcoholic Intoxication		1-3 weeks	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) (1) Fatty degenerative liver (?) Diabetes Mellitus							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 217 W. Wash. St. Hagerstown, Maryland					22b DATE SIGNED 2/6/68
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE Feb. 7, 1968	23c NAME OF CEMETERY OR CREMATORIAL Pleasant Hill Cemetery		23d LOCATION (City or Town) Coseytown Pa. (County) (State)		
24 FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Md.		ADDRESS		25a REC'D BY REGISTRAR	25b REGISTRAR'S SIGNATURE DATE FEB 9 1968 Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

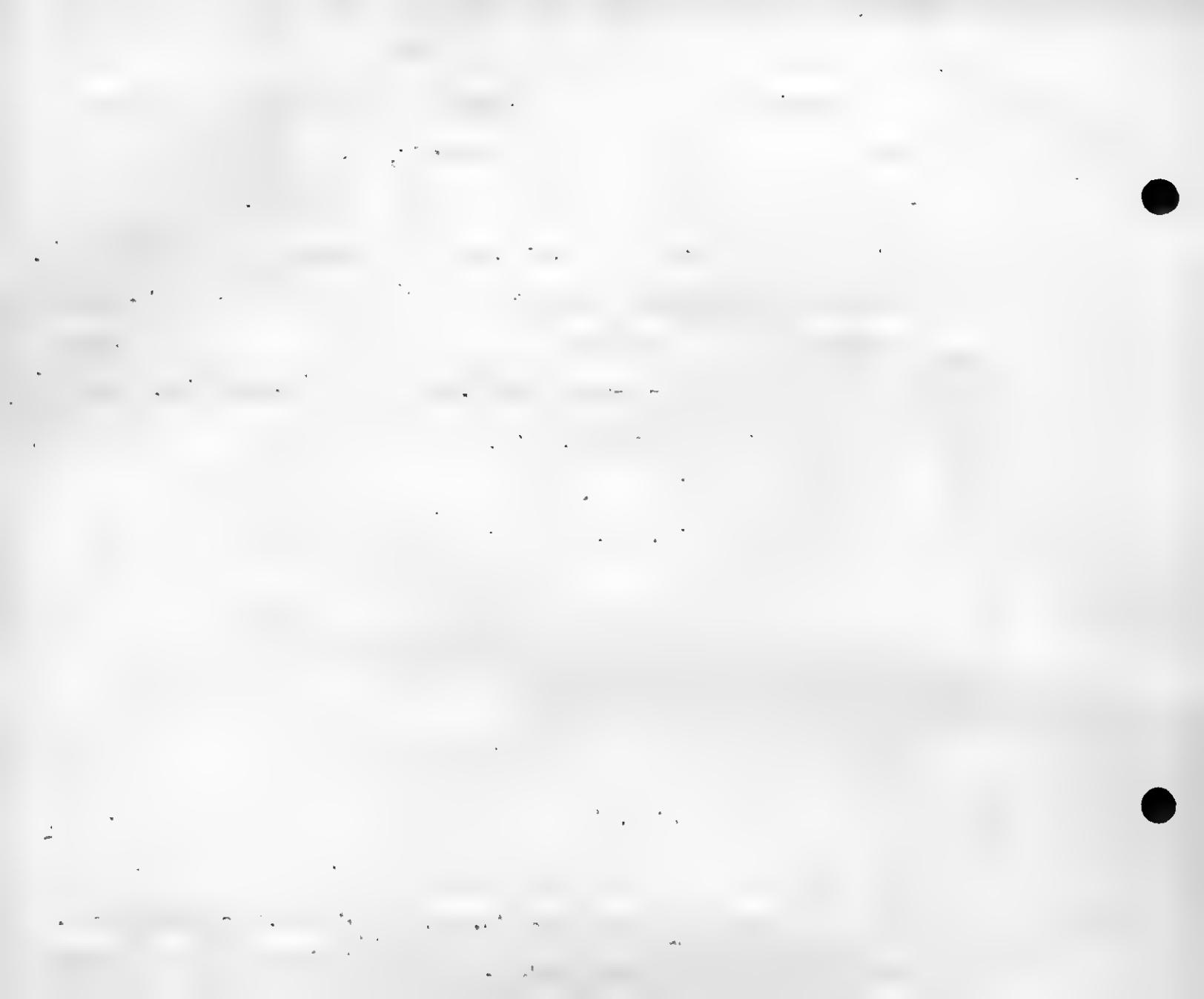
1. DECEASED-NAME (Type or print)	First William	Middle Ellsworth	Last Davis	20. DATE OF DEATH Month Feb. 28 1968	2b. HOUR 3:25 P M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 10 1883		6. AGE (In years last birthday) 84 yrs	IF UNDER MONTHS 6	YEAR 18	IF UNDER 24 HRS. DAYS HOURS MIN
7a BIRTHPLACE (State or foreign country) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		Md.		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Washington Co.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret'd Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland	lived, if institution. Residence before 13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMIT? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 19 Roessner Ave.			
14. FATHER'S NAME J	First Ellsworth	Middle Davis	15. MOTHER'S MAIDEN NAME Sarah		Middle Ellen	Last Cross	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO. 212-14-5419	17. INFORMANT Mr. Robert W. Davis		207 Jackson Ave. Hagerstown Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT (CEREBRAL THROMBOSIS)</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 19 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>PNEUMONIA</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> , 19 <u>66</u> , to <u>2/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>3/6/68</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>R. Amarillo</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>3/1/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>R. AMARILLO</u>		22e. ADDRESS <u>SHARPSBURG, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE March 2, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery	23d. LOCATION (City or Town) Sharpsburg	(County) Washington	(State) Md.	
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport Maryland		25a. REC'D BY REGISTRAR DATE MAR 4 1968	25b. REGISTRAR'S SIGNATURE <u>Albert L. Leaf</u>		



5212
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove from paper. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Domenico	Middle	Last DeMatteis	2a. DATE OF DEATH Month February	Day 20	Year 1968	2b. HOUR M
3. SEX Male	4. RACE White	S. DATE OF BIRTH August 17, 1879	6. AGE (In years lost birthday) 88	7. IF UNDER 1 YEAR MONTHS 0			
7a. BIRTHPLACE (State or foreign country) Italy	7b. CITIZEN OF WHAT COUNTRY? Italy	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington	8. IF UNDER 24 HRS. MONTHS 0			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance	12b. KIND OF BUSINESS OR INDUSTRY Cement Mfg.	13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland			
13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 483 Mitchell Ave.				
14. FATHER'S NAME First Joseph	Middle DeMatteis	15. MOTHER'S MAIDEN NAME First Maria	Middle Tripone				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. 213-10-6800	17. INFORMANT Paul D. DeMatteis	Address 483 Mitchell Ave. Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO, OR AS A CONSEQUENCE OF (c) Generalised Arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 45							
19a. DATE OF OPERATION 45	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. 2112-68-19	City or Town Hagerstown	County Washington	State Md.		
22a. I certify that (1) (this hospital) attended the deceased from 2/12/68 , to 2/20/68 , that (1) (we) last saw the deceased alive on 2/20/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert V. L. Campbell	DEGREE ATTENDING PHYS	22c. MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22d. DATE SIGNED 2/21/68			
22d. PHYSICIAN'S NAME (Type) Robert V. L. Campbell	22e. ADDRESS Hagerstown Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/23/68	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown-Washington Md.	(County) Washington	(State) Md.		
24. FUNERAL DIRECTOR Wm. C. Horan	ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.	25a. REC'D BY REGISTRAR Charles J. George	25b. REGISTRAR'S SIGNATURE Charles J. George	DATE FER 26 1968			



FOR STATE
HEALTH DEPT.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1218 8/1968

1 DECEASED NAME (Type or Print)	First George	Middle Warren	Last DeWolfe	2a DATE KNOWN OF ESTI. DEATH MATED 2-6	Month 1968	Day 8a M	2b HOUR 8a M
3 SEX male	4 RACE white	5 DATE OF BIRTH 9-30-12	6 AGE (in years last birthday) 55 yrs	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN 0
7a BIRTHPLACE (State or foreign country) Colorado	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington	12c. DATE PRONOUNCED DEAD Month 2	Day 6	Year 1968	2d HOUR 9:40 A.M.
10 CITY OR TOWN OF DEATH Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) rural			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) engineer			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Ohio	13b COUNTY Marion	13c. CITY OR TOWN Marion	13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e STREET AND NUMBER 807 S. Prospect St.			
14 FATHER'S NAME First Marshall	Middle E.	Last DeWolfe	15 MOTHER'S M AIDEN NAME First Esther	Middle Neely	Last	Md. KIND OF BUSINESS OR ROBSPANE construction	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 276-09-3509	17 INFORMANT Walter Deming Mortuary, Marion, Ohio	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) gunshot wound of Head APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE OR CONDITION GIVEN IN PART 1(a) 976X							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNA. CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR AM 2/6/1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) gun shot wound of Head			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Motel		21f. LOCATION Street or RFD No 11 North, Hagerstown		City or Town Wash. Md.	County Wash.
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto, III							
EXAMINER'S NAME (Type) Dr. E. W. Ditto, III							
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation	23b. DATE 3-7-68	23c. NAME OF CEMETERY OR CREMATORIAL Lee Crematory	23d. LOCATION (City or Town) Washington, D.C.	(County) D.C.	(State) D.C.		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.	ADDRESS			25a. REC'D BY REG STRR DATE FEB 9 1968	25b. REGISTRAR'S SIGNATURE John J. S. [Signature]		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

33196

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

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1. DECEASED-NAME (Type or print)		First Grace	Middle Elizabeth	Last Domer	2a. DATE OF DEATH Month February	Day 9, 1968	Year	2b. HOUR 2 A. M.			
3. SEX Female		4. RACE White	5. DATE OF BIRTH July 28 1898		6. AGE (in years last birthday) 69		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington.					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 9 w/ street address) 162 Mill Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. US. AT RESIDENCE (Where deceased admission) STATE Maryland		13b. CITY OR TOWN Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 162 Mill St			
14. FATHER'S NAME George Metz		15. MOTHER'S MAIDEN NAME Martha Lizer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Frances Peters 36 E. Washington St		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE a. <i>Liver Carcinoma.</i>		DUE TO, OR AS A CONSEQUENCE OF b. <i>Melastoma</i>		Hagerstown Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF c. <i>Adeno Carcinoma recta</i>				6 mo. to 1 yr.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
MEDICAL CERTIFICATION		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>53</u> to <u>death</u> , that (I) (we) last saw the deceased alive on <u>2-7</u> , 19 <u>68</u> and that in (my) his opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not (did not) view the body after death.											
22b. SIGNATURE <i>Robert F. Keadle</i>		22c. DATE SIGNED <u>2-9-68</u>									
22d. PHYSICIAN'S NAME (Type) Robert F. Keadle		22e. ADDRESS Hagerstown									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/11/68		23c. NAME OF CEMETERY OR CREMATORIAL Bakersville Cem		23d. LOCATION (City or Town) Bakersville Wash Co		(County) Md		(State)	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		ADDRESS		25a. REC'D BY REGISTRAR FEB 13 1968		25b. REGISTRAR'S SIGNATURE <i>g</i>					



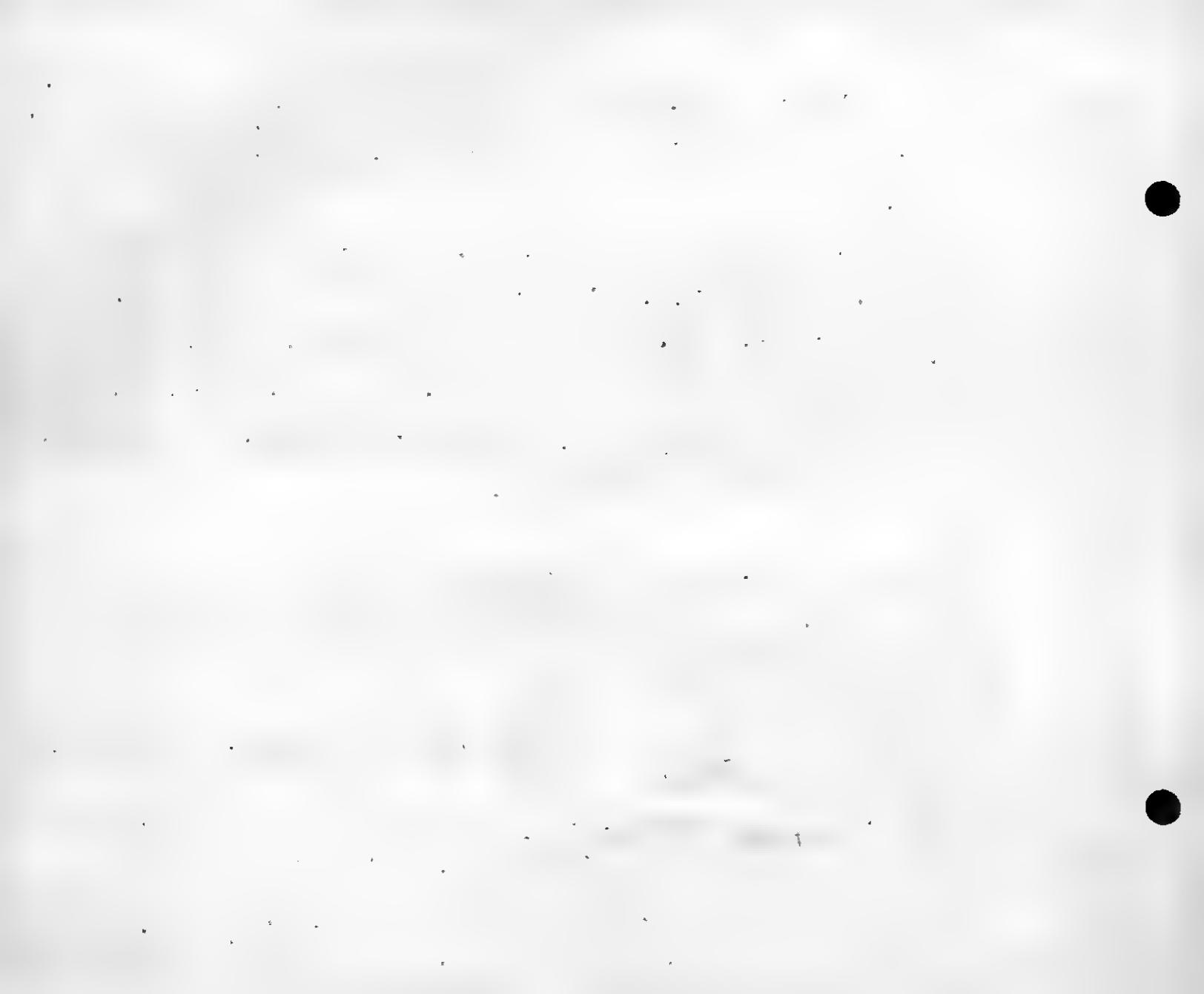
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)		First Abner	Middle LeRoy	Last Doub	2a. DATE OF DEATH Month February Day 17 Year 1968	2b. HOUR 6:45 P.M.
3. SEX male		4. RACE white	5. DATE OF BIRTH 3-19-1889		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS M.N.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 205 Phylane Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) farmer		12b. KIND OF BUSINESS OR INDUSTRY farming
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 205 Phylane Dr.	
14. FATHER'S NAME First Abner		Middle F.	Last Doub	15. MOTHER'S MAIDEN NAME First Middle Susanna, Stockslager		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-36-7180		17. INFORMANT Address Emma M. Doub, Hagerstown, Md.		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Arterio-sclerotic heart disease</i> APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>412 1</i> BETWEEN ONSET AND DEATH <i>412 1</i></p> <p>(b) <i>Emphysema</i></p> <p>(c)</p>						
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>Recent transurethral Resection Prostate</i></p>						
19a. DATE OF OPERATION July 7-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bladder neck obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or RFD No.	City or Town	County	State
<p>22a. I certify that (I) (this hospital) attended the deceased from Sept 24, 1968, to Sept 24, 1968, that (I) (we) last saw the deceased alive on Sept 24, 1968, and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>						
<p>22b. SIGNATURE <i>Sidney W. Hansen</i></p>						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Funkstown MD		22c. DATE SIGNED 2-19-68		
23a. BURIAL CREMATION, REMOVAL (Specify) burial		23b. DATE 2-20-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown (County) Md. (State)		
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		ADDRESS Minnich Funeral Home, Hagerstown, Md.	25a. REGD. BY REC'D. BY DATE Feb 21 1968	25b. REGD. BY REC'D. BY DATE Feb 21 1968		



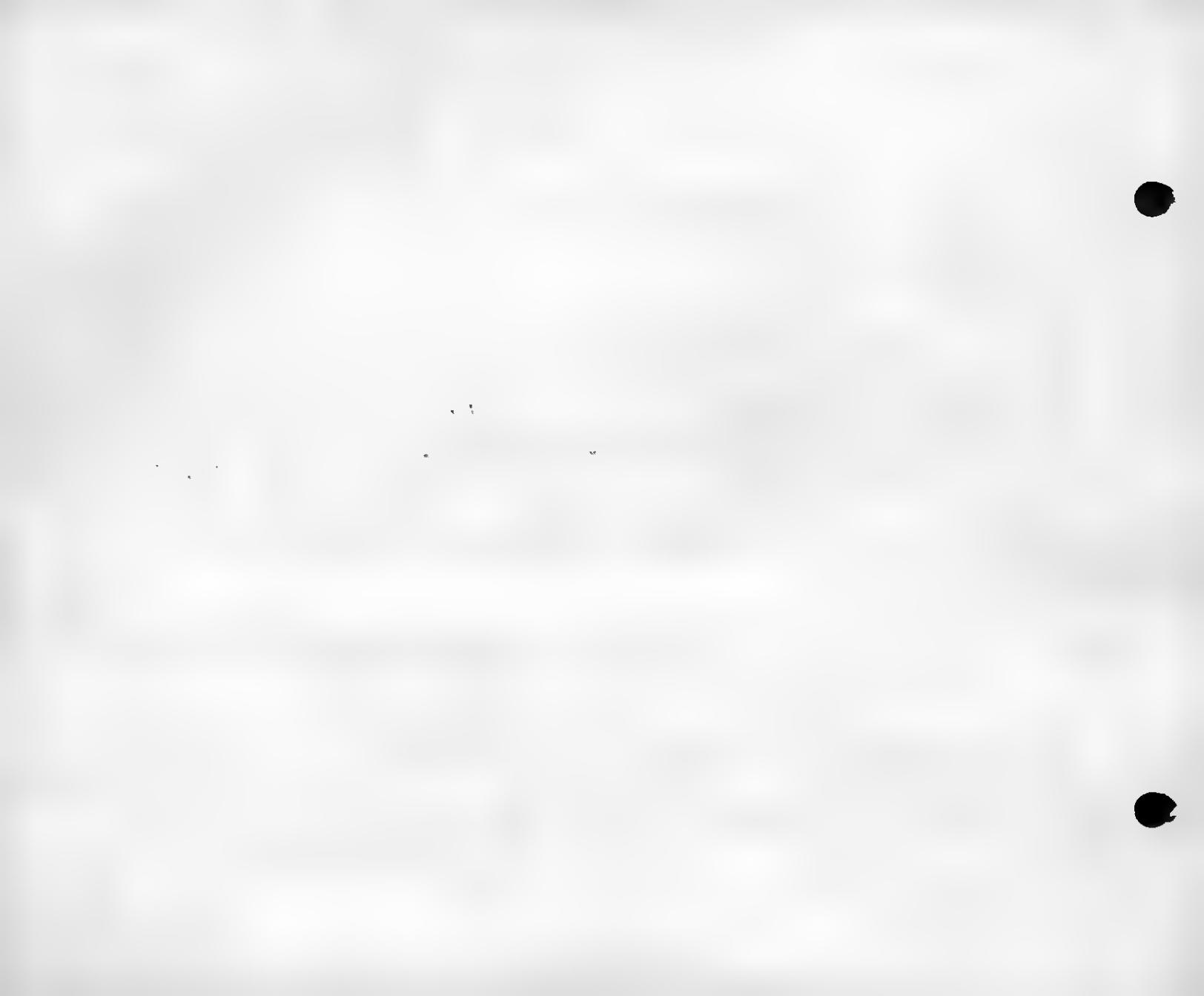
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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3219		3219	
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE MD. b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b -	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 1670 SALEM Ave., Ext.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1670 SALEM Ave., Ext.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) THEODORE R. EBY		First	Middle
4. DATE OF DEATH February 13 1968		Month	Day
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/22/1884		9. AGE (in years last birthday) 83 yrs	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10. USUAL OCCUPATION (Give kind of work done during most of work not life span if different) FARMER		11. BIRTHPLACE (County & State or foreign country) WASH. Co., Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Reuben H. Eby		14. MOTHER'S MAIDEN NAME Amanda Reiff	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Mrs. Emma Eby - 1670 Salem Ave. Hagerstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4127		INTERVAL BETWEEN ONSET AND DEATH 1 month	
b) Arteriosclerotic heart disease indefinite DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia, rt. lower lobe active but not cause of death			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter notes of injury in Part I or Part II of item 18) death	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2-10 1968 , and that death occurred at 3 A.M. from causes and on the date stated above.		21. to 19 00 19 death 19	22b. DATE SIGNED
22a. SIGNATURE Robert F. Keadle		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) ROBERT F. KEADLE		22d. ADDRESS 580 NORTHERN Ave., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/15/68	23c. NAME OF CEMETERY OR CREMATORIAL REIFF CH. CEM.
24. FUNERAL DIRECTOR A. E. Minnick - GREENCASTLE, Pa.		25a. ADDRESS 3	25b. REC'D BY REGISTRAR DATE 2/15/68
			25b. REGISTRAR'S SIGNATURE



4-1
33213
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First <i>Vernon</i>	Middle <i>Lee</i>	Last <i>Eckard</i>	2a. DATE OF DEATH Month <i>February</i>	Day <i>21</i>	Year <i>1968</i>	2b. HOUR <i>5:00pm</i>							
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>May 3, 1889</i>		6. AGE (In years last birthday) <i>78</i> YRS.									
7a. BIRTHPLACE (State or foreign country) <i>Luray, Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>									
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>1729 Salem Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Conductor</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Railroad</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>		13e. STREET AND NUMBER <i>1729 Salem Ave.</i>							
14. FATHER'S NAME First <i>Jacob</i>		Middle <i>Eckard</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Lonella</i>		Middle <i>Frances</i>	Last <i>Decker</i>	Address <i>Mrs. V. L. Eckard 1729 Salem Ave. Hagerstown, Md.</i>							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown <i>No</i>										16b. SOCIAL SECURITY NO. <i>705-10-8227</i>		17. INFORMANT <i></i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4 / / DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i></i>										19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 422 <i></i>					
19a. DATE OF OPERATION <i>4/22/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i></i> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>		21d. LOCATION Street or R.F.D. No. City or Town County State <i></i>									
21e. PLACE OF INJURY At HOME, FARM, STREET, FACTORY, (OFFICE BUILDING, ETC.) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. LOCATION Street or R.F.D. No. City or Town County State <i></i>													
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1, 1968</u> , to <u>Feb. 21, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 16, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>E. W. Ditto</i>		DEGREE <i></i>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <i>Feb. 22, 1968</i>									
22d. PHYSICIAN'S NAME (Type) <i>Dr. E. W. Ditto, Jr.</i>		22e. ADDRESS <i>215 W. Washington St., Hagerstown, Md.</i>													
23a. BURIAL, CREMATION ON, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/24/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) <i>Hagerstown-Washington Md.</i>		(County) <i></i>		(State) <i></i>					
24. FUNERAL DIRECTOR <i>W. C. Wood</i>		ADDRESS <i>Rest Haven Funeral Chapel</i>		25a. REC'D BY REG. STRR. <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jagger</i>		DATE <i>FEB 26 1968</i>							



MARYLAND STATE DEPARTMENT OF HEALTH

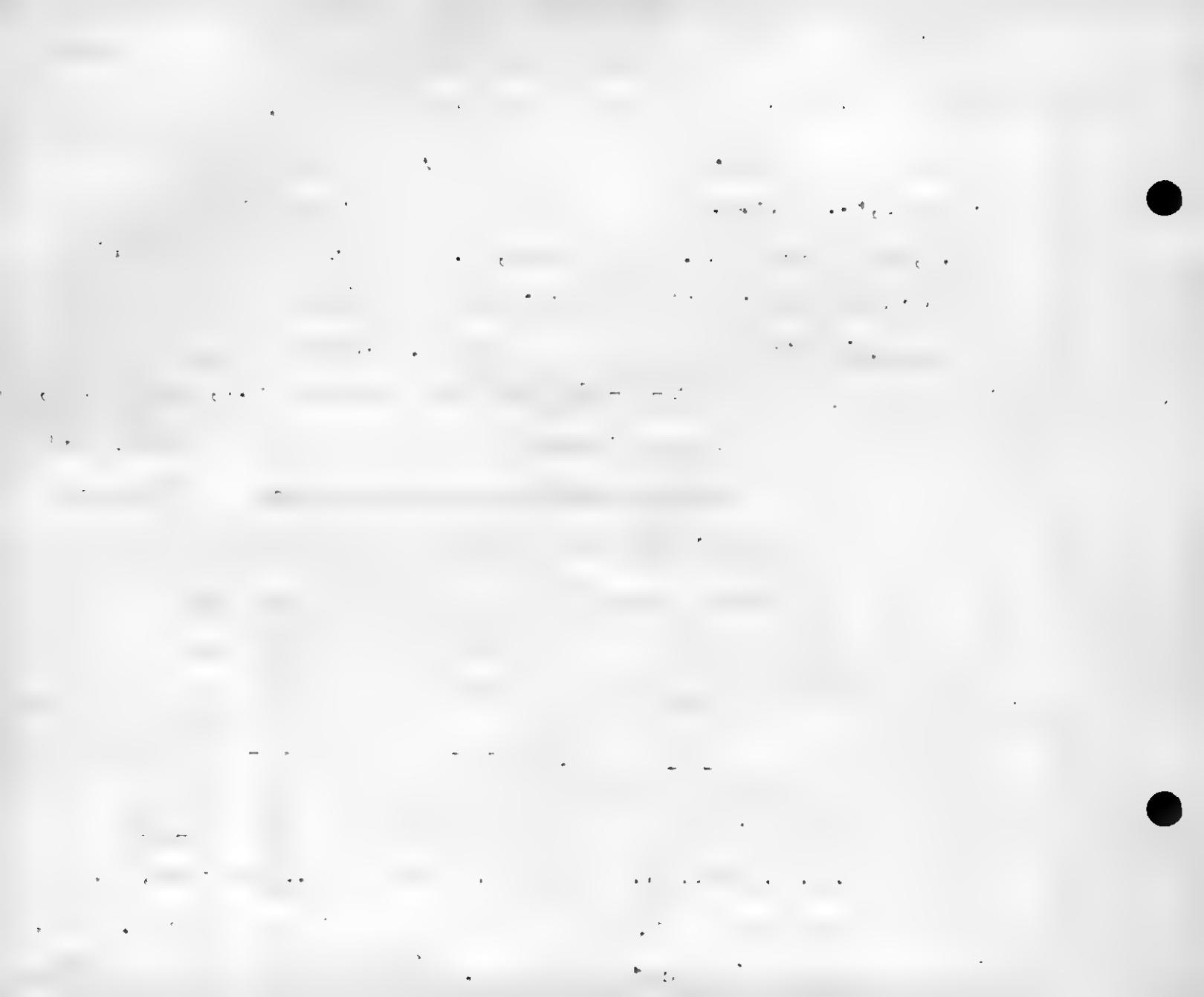
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13218

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1 DECEASED NAME (Type or print)	First Clarence	Middle Hershey	Last Eckstine	2a. DATE OF DEATH Feb. 12 1968	2b. HOUR 78 YRS.
3 SEX Male	4 RACE White	5. DATE OF BIRTH 5/7/89		6. AGE (In years lost birthday) 78	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Fairview, Pa.	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED WIDOWED	NEVER MARRIED DIVORCED	9 COUNTY OF DEATH Washington	
10 CITY OR TOWN OF DEATH Rd. 4, Hagerstown	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rd. 4 Hagerstown, Md.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Retired	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13c CITY OR TOWN Washington	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Route 4		
14. FATHER'S NAME John R. Eckstine	First Middle Last	15. MOTHER'S MAIDEN NAME Emma S. Hershey	Middle	lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. None	17 INFORMANT Mrs Ruth Eckstine	Address Rd. 4, Hagerstown, MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4/29 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma Prostate</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several day's					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15</u> , 19 <u>67</u> , to <u>2-12</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-12</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>N. E. W. Ditto</u>		DEGREE ATTENDING PHYS.	MED. DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2-13-68
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.	22e. ADDRESS 215 W. Washington St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/15/68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Tabor Luthern	23d. LOCATION (City or Town) Fairview	(County) Wash.	(State) Md.
24. FUNERAL DIRECTOR Margaret Rowland	ADDRESS Clear Spring, Md.	25a. REC'D BY REGISTRAR FEB 16 1968	25b. REGISTRAR'S SIGNATURE Charles Yeager		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1
10219
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers page 7 and 8, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR AM	
Miss Pauline				Enzle		Feb.	1	1968	7 A M	
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Female		White	April 2, 1881			86 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Germany		U. S. A.				Washington			Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Williamsport, Maryland		Homewood Church Home			Domestic			Domestic		
13a. USUAL RESIDENCE (Where deceased lived, if institution). Reside before admission		STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER	2801 Jamestown Rd.		
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last	
Jacob Enzle					Anna Schneeberger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT		Address			
No		None 219-54-0954			Rev. Mark G. Wagner		2750 Virginia Ave Williamsport, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY.										
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> APPROXIMATE INTERVAL 410.9 BETWEEN ONSET AND DEATH Conditions, if any, which gave <u>15 min</u> rise to immediate cause (a), stating the underlying cause <u>Gen. Atherosclerosis</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Gen. Atherosclerosis</u> 10 yrs										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>67</u> , to <u>2-1</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-24</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		Robert P. Conrad			DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 2-1-68	
22d. PHYSICIAN'S NAME (Type)		Robert P. Conrad, MD			22e. ADDRESS		Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)
Burial		Feb. 3, 1968		Cedar Hill Cemetery			Sutland		Maryland	
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Andrew K. Coffman Funeral Home Inc.					FEB 2 1968		Charles J. Judge			
30M REV. 1-68					DATE					



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First Benton	Middle Montgomery	Last Ewing	2a. DATE OF DEATH 2 Month 12 Day 68 Year	2b. HOUR 9 a.m.
3. SEX Male		4. RACE White		5. DATE OF BIRTH 2/3/07		6. AGE (In years lost birthday) 61 yrs.	IF UNDER MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY Md.
13a. USUAL RESIDENCE (Where deceased admission) STATE Pa.		13b. COUNTY Salisbury		13c. CITY OR TOWN Salisbury	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. 1, Box 128C	
14. FATHER'S NAME First Joseph		Middle Ewing	Last	15. MOTHER'S MAIDEN NAME First Smith		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO 101-12-7599		17. INFORMANT 22		Address	
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> 4 mo.</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause most</p> <p>(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>19a. DATE OF OPERATION</p> <p>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
<p>22a. I certify that (I) (the physician) attended the deceased from <u>2/5</u>, 19<u>68</u>, to <u>2/12</u>, 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>2/12</u>, 19<u>68</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> <p>22b. SIGNATURE <u>Domingo A. Garcia</u></p> <p>22c. DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. PHYSICIAN'S NAME (Type) Domingo A. Garcia, M.D.</p> <p>22e. ADDRESS Western Md. State Hospital, Hagerstown</p> <p>22f. DATE SIGNED 2/12/68</p>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/15/68</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Grantsville Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Grantsville, Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Bob Neuman</u>				ADDRESS		25a. REC'D. BY REGISTRAR DATE <u>FEB 16 1968</u>	25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>



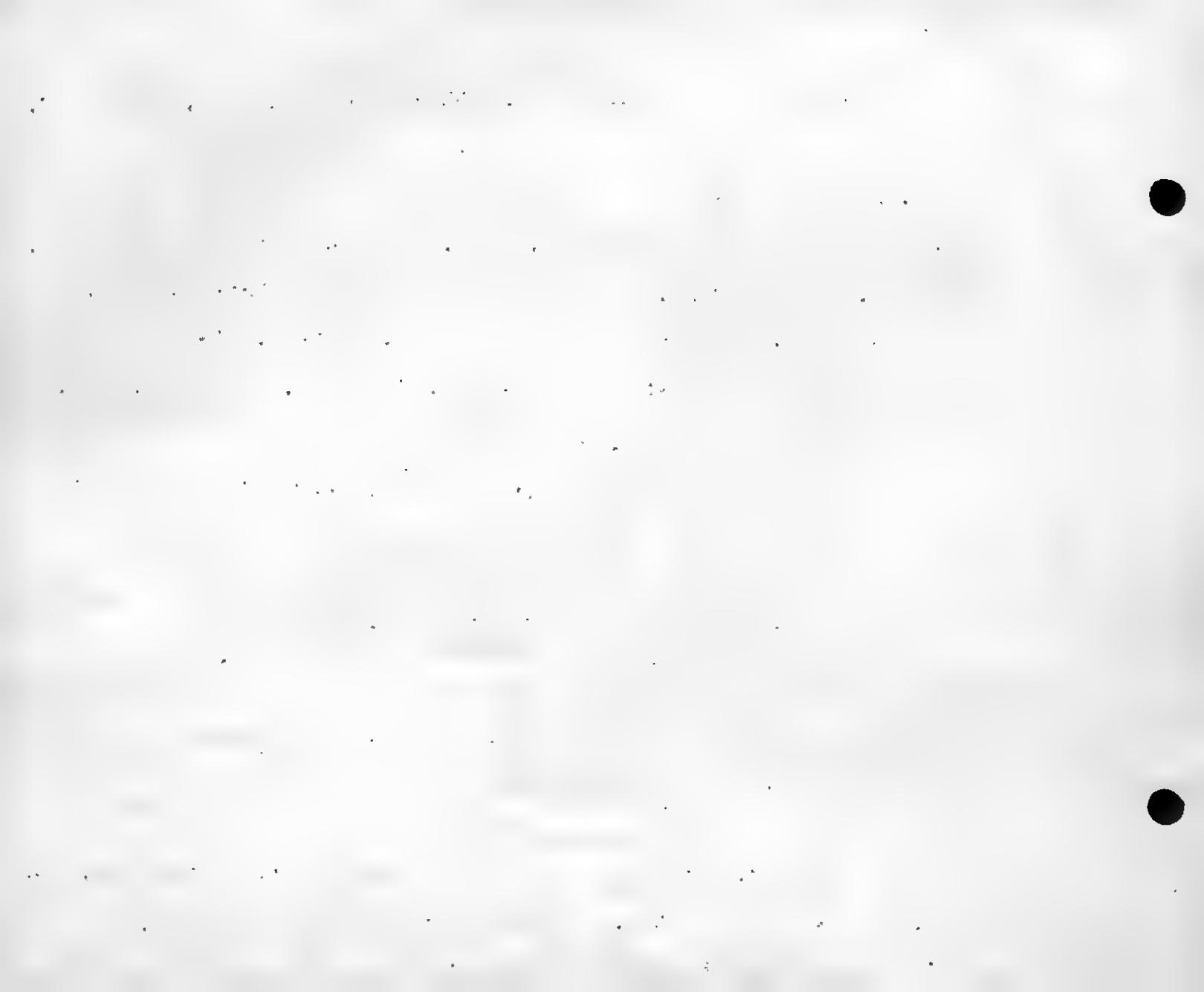
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10227
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10320.1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. *Robert F. Keadle* and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First MORRIS	Middle MC CLELLAN	Last FLETCHER	2a. DATE OF DEATH Month February Day 24 Year 1968	2b. HOUR 3:10 P. M.
3. SEX male	4 RACE white	5. DATE OF BIRTH Feb. 2, 1899		6. AGE (In years last birthday) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) edge setter	12b. KIND OF BUSINESS OR INDUSTRY shoe mfg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY J.MITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 122 Englewood Dr.	
14. FATHER'S NAME First George W. Fletcher	Middle 	Last 	15. MOTHER'S MAIDEN NAME First Isabell T. Winkfield	Middle 	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown yes	16b. SOCIAL SECURITY NO. WW 11 214-09-5177	17. INFORMANT Mary R. Fletcher, Hagerstown, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Myocardial infarction minutes DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 4211 Atherosclerotic heart disease indef (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Employment.					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 11 MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY.) (OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 2 - 16	City or Town deceased	County 19
22a. I certify that (I) (this hospital) attended the deceased from 2 - 16 , 1968, to deceased , that (I) (we) last saw the deceased alive on 2 - 24 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert F. Keadle		DEGREE 	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>
22d. PHYSICIAN'S NAME (Type) Robert F. Keadle		22e. DATE SIGNED 			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-27-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County)
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		ADDRESS 	25a. REC'D BY REGISTRAR DATE FEB 28 1968	25b. REGISTRAR'S SIGNATURE Charles J. ...	

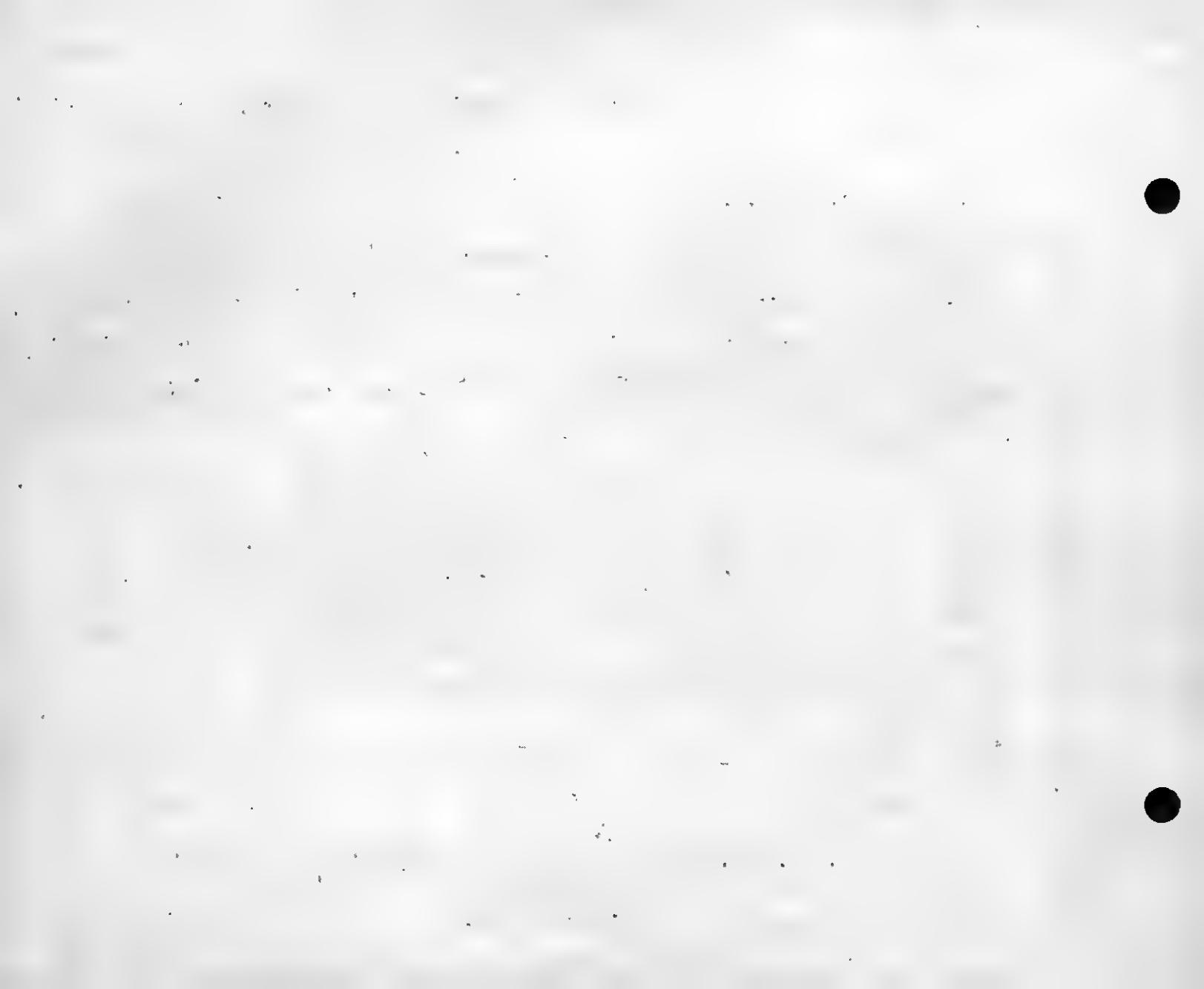


5222
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If you please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First James	Middle Riley	Last French	2a. DATE OF DEATH Month Feb.	Day 28	Year 1968	2b. HOUR 7:15PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH Dec. 25 1892		6 AGE (In years last birthday) 75	IF JUNIOR 1 YEAR 2	IF UNDER 24 HRS MONTHS 2	IF HOURS DAYS 2
7a. BIRTHPLACE (State or foreign country) Wash. Co. Md. U.S.A	7b. CITIZEN OF WHAT COUNTRY? Washington	8 MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Washington Co.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret'd Interior Decorator	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission). STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER RFD #2 Walnut Pt. Road			
14. FATHER'S NAME Robert Bucannan	First Middle French	Last	15. MOTHER'S MAIDEN NAME Catherine E. Taylor	Middle	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) None	16b. SOCIAL SECURITY NO None	17. INFORMANT Mrs. Carrie C. French	Address Hagerstown. I.d RFD 2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Worms</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriovenous hypoxia</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>many years</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Generalized arteriovenous, bronchial asthma</i>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 2-16 , 1968, to 2-28 , 1968, that (I) (we) last saw the deceased alive on 2-28 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edson B. Moody</i>	22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 2-28-68			
22d. PHYSICIAN'S NAME (Type) Dr. Edson B. Moody	22e. ADDRESS 363 S. Cleveland Ave. Hagerstown, Maryland 21740						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE March 2-68	23c. NAME OF CEMETERY OR CREMATORIAL Salem Church Cemetery	23d. LOCATION (City or Town) Cearfoss	(County) Washington	(State) Md.		
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE MAR 4 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jette</i>			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

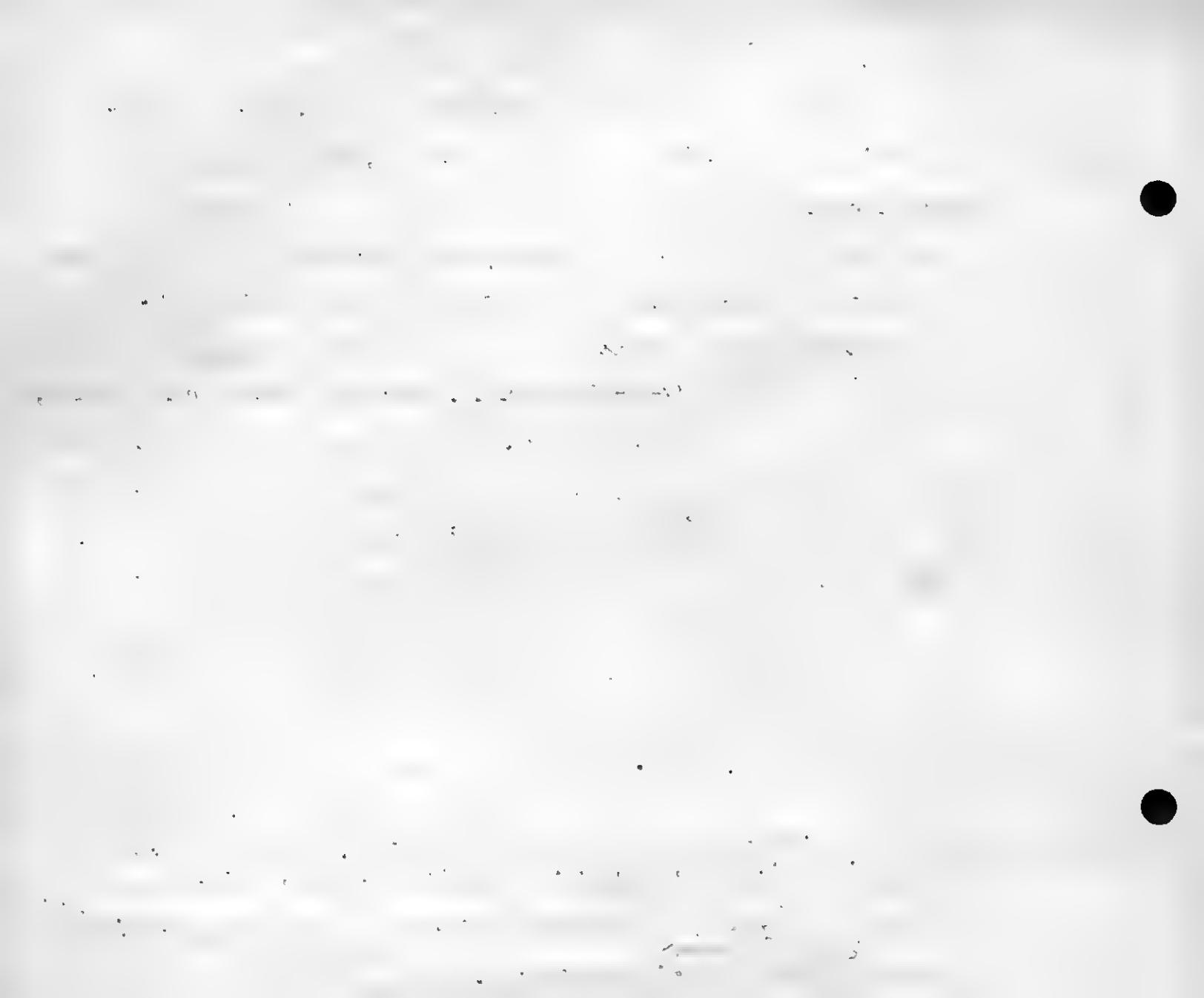
Item 5 Film G397 2/19/68 kk

CERTIFICATE OF DEATH

03201

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <i>Anne</i>	Middle <i>Mable</i>	Last <i>Groehlich</i>	2a. DATE OF DEATH Month <i>February</i>	Day <i>15</i>	Year <i>1968</i>	2b. HOUR <i>M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>January 22, 1886</i>		6. AGE (In years last birthday) <i>82</i>	7. IF UNDER 1 YEAR MONTHS <i>82</i>		
7a. BIRTHPLACE (State or foreign country) <i>Adams Co., Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Washington</i>		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Avalon Manor Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Maryland</i>	13b. COUNTY <i>Washington</i>	13c. CITY OR TOWN <i>Hagerstown</i>	13d. INSIDE CITY LIMITS? <i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>	13e. STREET AND NUMBER <i>7 Glenside Ave.</i>			
14. FATHER'S NAME First <i>Francis</i>	Middle <i>Edmund</i>	Last <i>Mans</i>	15. MOTHER'S MAIDEN NAME First <i>Susanna</i>		Middle <i>Rebecca</i>	Last <i>Shank</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>217-10-95498</i>		17. INFORMANT <i>Mrs. J.C. Huggin</i>		Address <i>1106 Sherman Ave. Hagerstown, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Bilateral lobular pneumonia</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3-5 days</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>154 x</i> (b) <i>Malignant Sarcoma of Rectum</i> <i>1-2 yrs</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>abdominal metastasis</i>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cholelithiasis + ch. cholecystitis, arterio sclerotic vascular Disease</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (This hospital) attended the deceased from <i>Jan 6, 1968</i> , to <i>Feb 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edward W. Ditto, III, M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>2/15/68</i>		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>217 W. Washington Street</i>		Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/17/68</i>	23c. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown Washington Md</i>		
24. FUNERAL DIRECTOR <i>Wm. C. Harrof</i>		ADDRESS <i>Rest Haven Funeral Chapel. Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR <i>FEB 19 1968</i>	25b. BORN/DEA'D'S SIGNATURE <i>Edward J. Judge</i>		

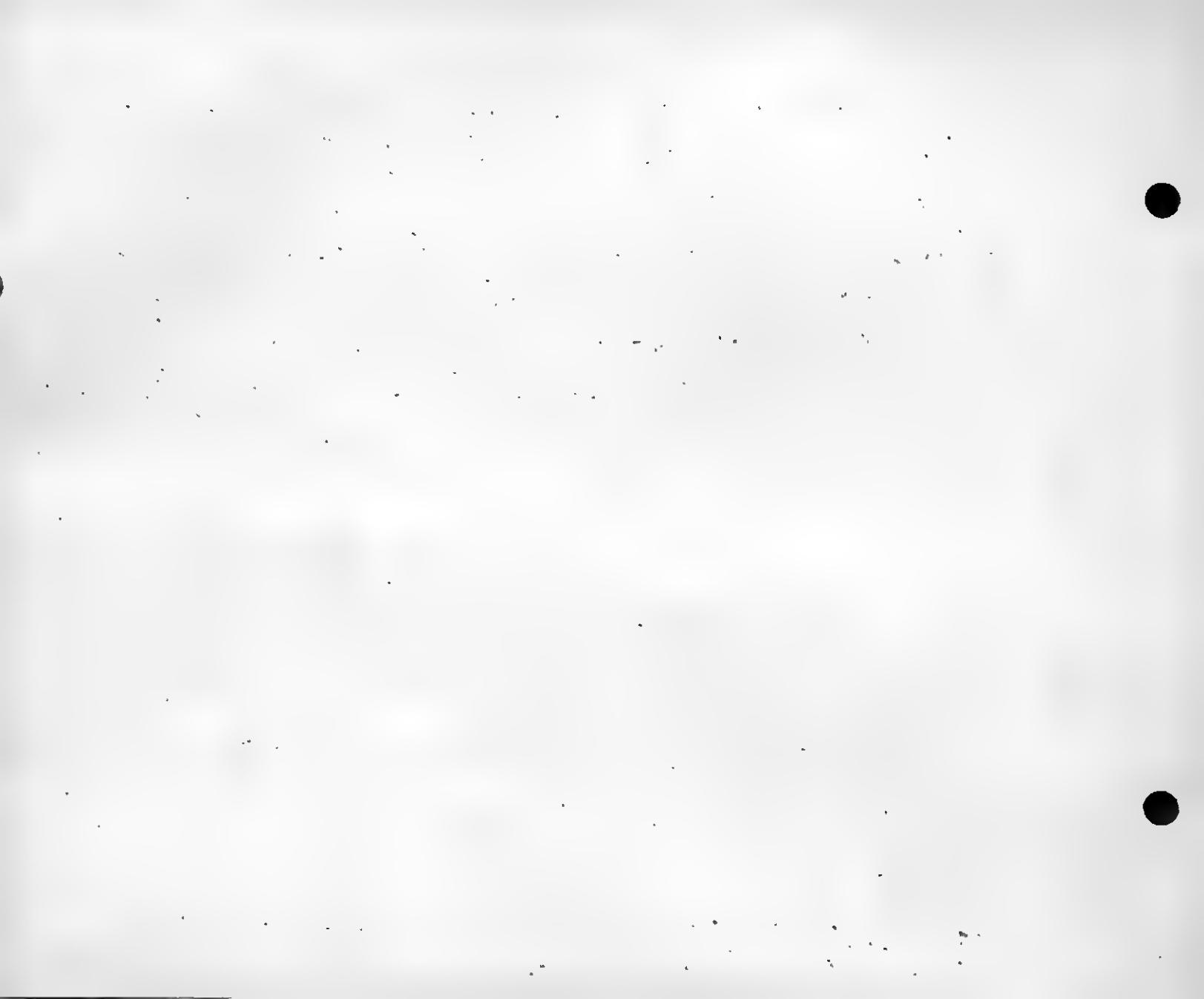


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

7
15224
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)		First <i>DARWIN Roy</i>	Middle <i>GATES</i>	Last <i>GATES</i>	2a. DATE OF DEATH Month <i>Feb</i>	Day <i>24</i>	Year <i>1968</i>	2b. HOUR 2:15 AM						
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>	5. DATE OF BIRTH <i>MARCH 3, 1890</i>		6. AGE (in years last birthday) <i>77</i>		7. IF UNDER 1 YEAR MONTHS <i>0</i>		8. IF UNDER 24 HRS. DAYS <i>0</i>		9. HOURS MIN <i>0</i>			
7a. BIRTHPLACE (State or foreign country) <i>PENNA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>WASHINGTON</i>								
10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WASHINGTON County</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Gasoline Operator</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Mining</i>								
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>W. Va.</i>		13b. COUNTY <i>MORGAN</i>		13c. CITY OR TOWN <i>Berkeley Springs</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>Lee Circle</i>						
14. FATHER'S NAME First <i>WILLIAM M. GATES</i>		Middle <i></i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>EMMA</i>		Middle <i>B.</i>	Last <i>HOLT</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>233-26-8868</i>		17. INFORMANT <i>Mrs. D.R. GATES</i>		Address <i>BERKELEY SPRINGS, W. Va.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>						
18. CAUSE OF DEATH (Enter on a line cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Co. e. co. gas tank</i>														
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>														
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>177X Arteriosclerosis, Syphilitic</i>														
19a. DATE OF OPERATION <i></i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>none</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i></i> Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>										
21d. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY (OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. City or Town County State										
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 17, 1968</i> , to <i>Feb 24, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>J. H. GATES</i>								22c. DATE SIGNED <i>2-24-68</i>						
22d. PHYSICIAN'S NAME (Type) <i>J. H. GATES</i>		22e. ADDRESS <i></i>												
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>Feb. 26, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>OAKLAND Cemetery Assoc.</i>		23d. LOCATION (City or Town) <i>INDIANA, Penn.</i>		(County) <i></i>		(State) <i></i>				
24. FUNERAL DIRECTOR <i>John D. Hunter</i>		ADDRESS <i>Berkeley Springs, W. Va.</i>		25a. REC'D BY REGISTRAR <i></i>		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>		DATE <i>FEB 26 1968</i>						



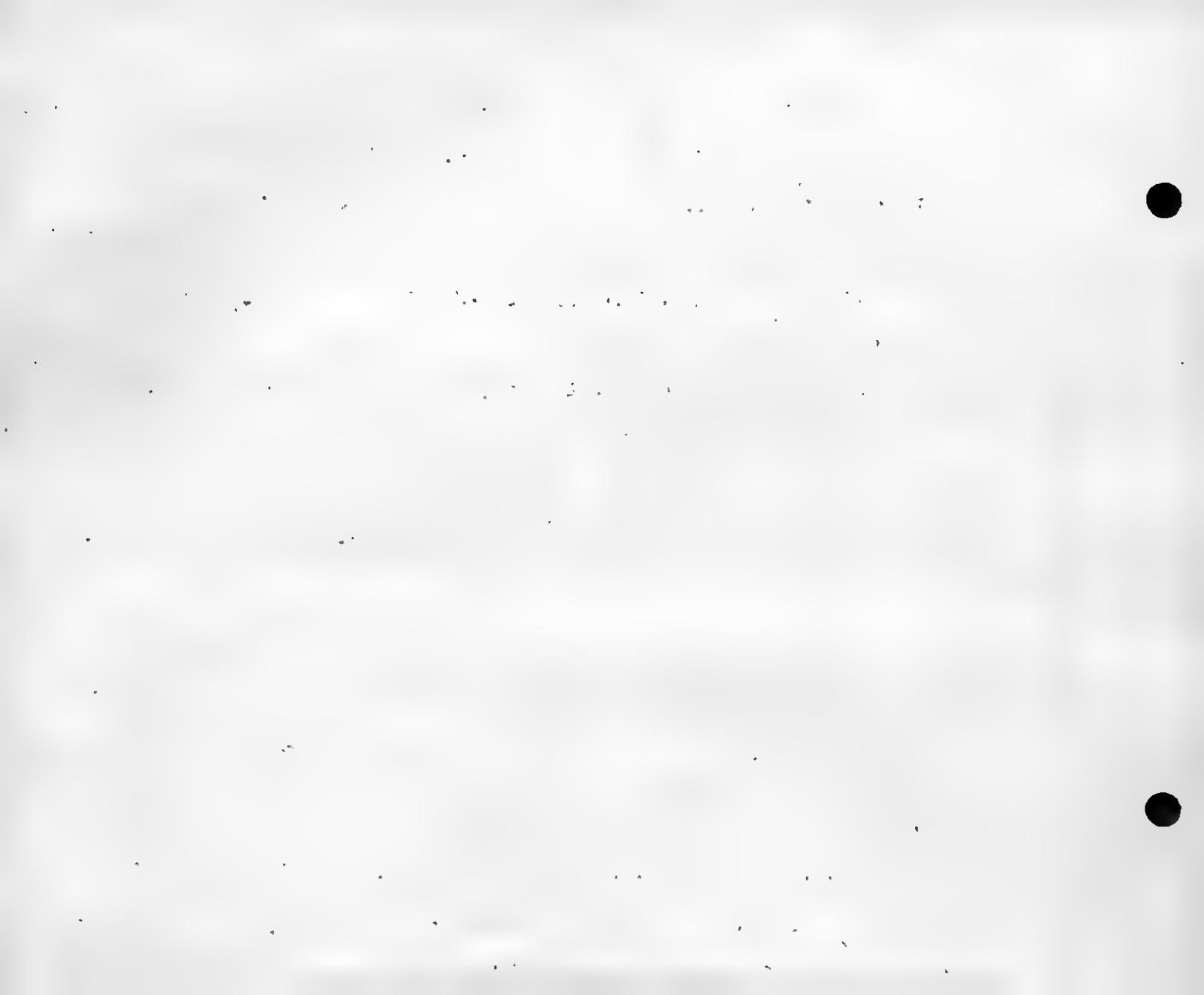
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

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1 DECEASED NAME (Type or print)		First CHARLES	Middle LEE	Last GOSSARD	2a. DATE OF DEATH Month FEB.	Day 24	Year 1968	2b. HOUR 7:50 am						
3 SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC 26 1895		6 AGE (In years last birthday) 72		7 IF UNDER 1 YEAR MONTHS 0	8 IF UNDER 24 HRS. DAYS 0	9 IF UNDER 16 HOURS 0	10 MIN 0			
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON		12b KIND OF BUSINESS OR INDUSTRY STOCKING FACTORY						
10. CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 121 McCOMAS ST		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MACHINIST		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND				13b. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 121 McCOMAS STREET	
14 FATHER'S NAME First JAMES		Middle E	Last GOSSARD	15. MOTHER'S MAIDEN NAME First Middle MARY SUSAN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO 214-09-4424		17 INFORMANT MRS. CATHERINE R GOSSARD		Address 121 McCOMAS ST HAGERSTOWN MD		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Bilateral (oblique) pneumonia		DUE TO, OR AS A CONSEQUENCE OF (b) Paroxysmal Agitation		DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										20 years				
21a. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		21b. DATE OF OPERATION		21c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21d. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)										
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State				
22a. I certify that (I) <input type="checkbox"/> attended the deceased from May 9 1966 to Feb 24 1968 , that (I) <input type="checkbox"/> last saw the deceased alive on Feb 22 1968 , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we) <input type="checkbox"/> (did) <input type="checkbox"/> (will) <input type="checkbox"/> view the body after death.														
22b. SIGNATURE Edward W. Ditto M.D.		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/>		22e. STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED 2/26/68						
22d. PHYSICIAN'S NAME (Type) E.W. DITTO 111 M.D.		22e. ADDRESS 217 W WASHINGTON ST HAGERSTOWN MARYLAND												
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/27/68		23c. NAME OF CEMETERY OR CREMATORIAL REST HAVEN CEMETERY		23d. LOCATION (City or Town) HAGERSTOWN		(County) WASHINGTON		(State) MD				
24. FUNERAL DIRECTOR Charles J. Jumper		ADDRESS HAGERSTOWN MARYLAND		25a. REC'D BY REG STRR Charles Jumper		25b. DATE FEB 27 1968		REGISTRAR'S SIGNATURE Charles Jumper						

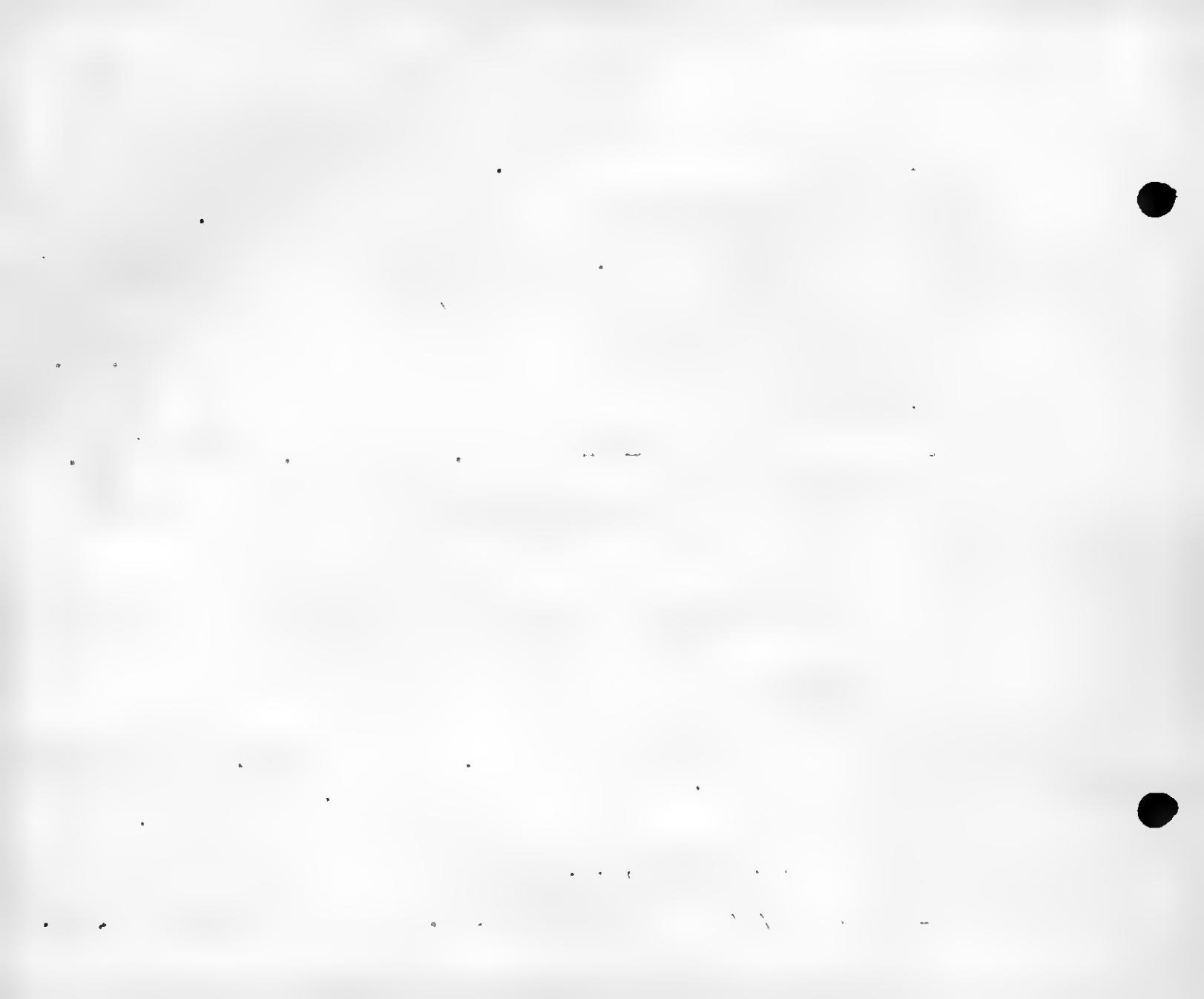


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 M
3226
1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
2 Page 4 may be retained by the hospital or attending physician.
3 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write NEAREST town) HAGERSTOWN		2 USUAL RESIDENCE (Where deceased lived if institution, residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
c LENGTH OF STAY IN 16 60 YRS.		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d STREET ADDRESS 707 WASHINGTON AVE.	
e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print)	First LULA	Middle E.	4 DATE OF DEATH FEBRUARY 6 1968
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/28/1887
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (County & State, or foreign country) VIRGINIA		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME MATHIAS P. HUPP		14. MOTHER'S MAIDEN NAME AMANDA ESTEP	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, Unknown) NO		16 SOCIAL SECURITY NO 214-09-4449	
17 INFORMANT MRS. MARGARET E. SHANK		18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung with metastasis to the pleura and heart INDEFINITE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 163X	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 50P.
21. I certify that (I) (this hospital) attended the deceased from Nov. 18, 1967 to Feb. 6, 1968 that (I) (we) last saw the deceased alive on Feb. 6, 1968 , and that death occurred at 50P. M, from causes and on the date stated above.		22b DATE SIGNED Feb. 7, 1968	
22a SIGNATURE B.B. Kneisley		22c PHYSICIAN'S NAME (Type) B.B. Kneisley, M.D.	22d ADDRESS 148 W. Washington Street Hagerstown, Maryland
23a BUR. A. CREMATION, REMOVAL BURIAL		23b DATE THEREOF 2/8/68	23c NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEM.
24 FUNERAL DIRECTOR W.J. Norment, Hagerstown, Md.		25a ADDRESS 148 W. Washington Street Hagerstown, Maryland	25b REC'D BY REGISTRAR DATE FEB 9 1968
		25c REGISTRAR'S SIGNATURE	



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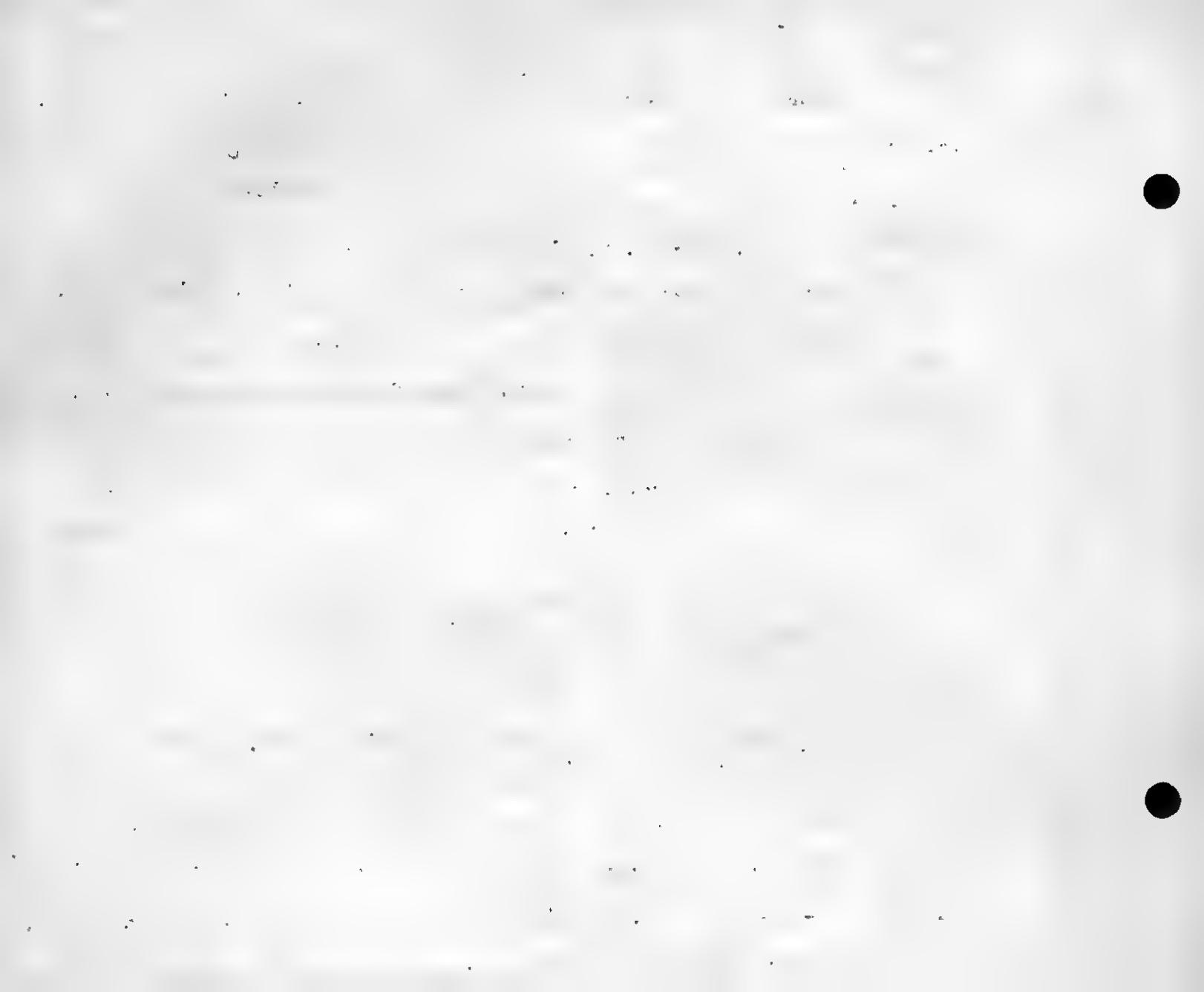
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03200

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1. DECEASED NAME (Type or print)		First Anna	Middle Hazel	Last Grove	2a. DATE OF DEATH 2 Month 14 Day 68 Year	2b. HOUR 5:45PM
3. SEX Female		4 RACE White	5. DATE OF BIRTH 2/19/17		6. AGE (In years last birthday) 50 YRS.	7. IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) housewife		12b. KIND OF BUSINESS OR INDUSTRY Md.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 1703 W. Washington St.	
14. FATHER'S NAME First Frederick		Middle Renner	15. MOTHER'S MAIDEN NAME First Melchora		Middle Harsh	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. -	17. INFORMANT Mr. Kenneth Grove Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 183.0		DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of ovary				unknown
3 years						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No		City or Town	County
						State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 6, 1968 , to Feb. 11, 1968 , that (I) (we) last saw the deceased alive on Feb. 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Victor L. Ramos, M.D.</i>		22c. DEGREE DEGREE	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input checked="" type="checkbox"/>	22d. DATE SIGNED 2/15/68
22d. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22e. ADDRESS Western Md. State Hospital, Hagerstown		Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-16-68	23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Cemetery		23d. LOCATION (City or Town) Clear Spring	(County) Md.
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR Charles J. Jones	25b. REGISTRAR'S SIGNATURE Charles J. Jones	DATE FEB 19 1968



FOR STATE
HEALTH DEPT

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours of death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or Print)			First Howard	Middle Samuel	Last Gruber	2a. DATE KNOWN OF ESTIMATE DEATH MATED			Month Feb. 1,	Day 1968	Year 8 P.M.	
3. SEX Male	4. RACE White	5. DATE OF BIRTH March 9, 1909	6. AGE (In years 58 month) YRS	7. IF UNDER 1 YEAR MONTHS 9 DAYS 23			8. IF UNDER 24 HRS HOURS 0 MIN			9. DATE PRONOUNCED DEAD Month Feb. Day 2 Year 1968 6 A.M.		
10. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? USA		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			13. COUNTY OF DEATH Washington			14. KIND OF BUSINESS OR INDUSTRY Tannery		
15. CITY OR TOWN OF DEATH Williamsport		16. NAME OF HOSPITAL OR INSTITUTION (If not a hospital give street address) 23 Fenton Ave.		17a. OCCUPATION (Kind of work done during most of working life, even if retired) Maintenance Man			17b. STREET AND NUMBER 23 Fenton Ave.					
18. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		19. CITY OR TOWN Washington		20. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			21. STREET AND NUMBER 23 Fenton Ave.					
22. FATHER'S NAME First Samuel		Middle Gruber	Last	23. MOTHER'S MAIDEN NAME First Annie			Middle L.	Last Shupp	24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
25. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)		26. SOCIAL SECURITY NO 215-14-1430		27. INFORMANT Mrs. Annie Gruber			28. ADDRESS Williamsport, Maryland			29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years		
30. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF 4109 Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <u>atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
31. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4201												
32. DATE OF OPERATION			33. CONDITION FOR WHICH OPERATION WAS PERFORMED			34. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
35. MEDICAL CERTIFICATION			36. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			37. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			38. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
39. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			40. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			41. LOCATION Street or R.F.D. No. City or Town County State						
42. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.												
43. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 580 Northern Ave. Hagerstown, Md.												
44. DATE SIGNED 2/2/68												
45. BURIAL, CREMATION, REMOVAL (Specify) Burial			46. DATE Feb. 5, 1968			47. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			48. LOCATION (City or Town) (County) (State) Clearspring, Washington, Md.			
49. FUNERAL DIRECTOR Albert L. Leaf			50. ADDRESS Williamsport, Md.			51. REC'D BY REGISTRAR DATE FEB 5 1968			52. REGISTRAR'S SIGNATURE Howard N. Weeks			
53. VITAL STATUS (5) 10M REV 1/68												



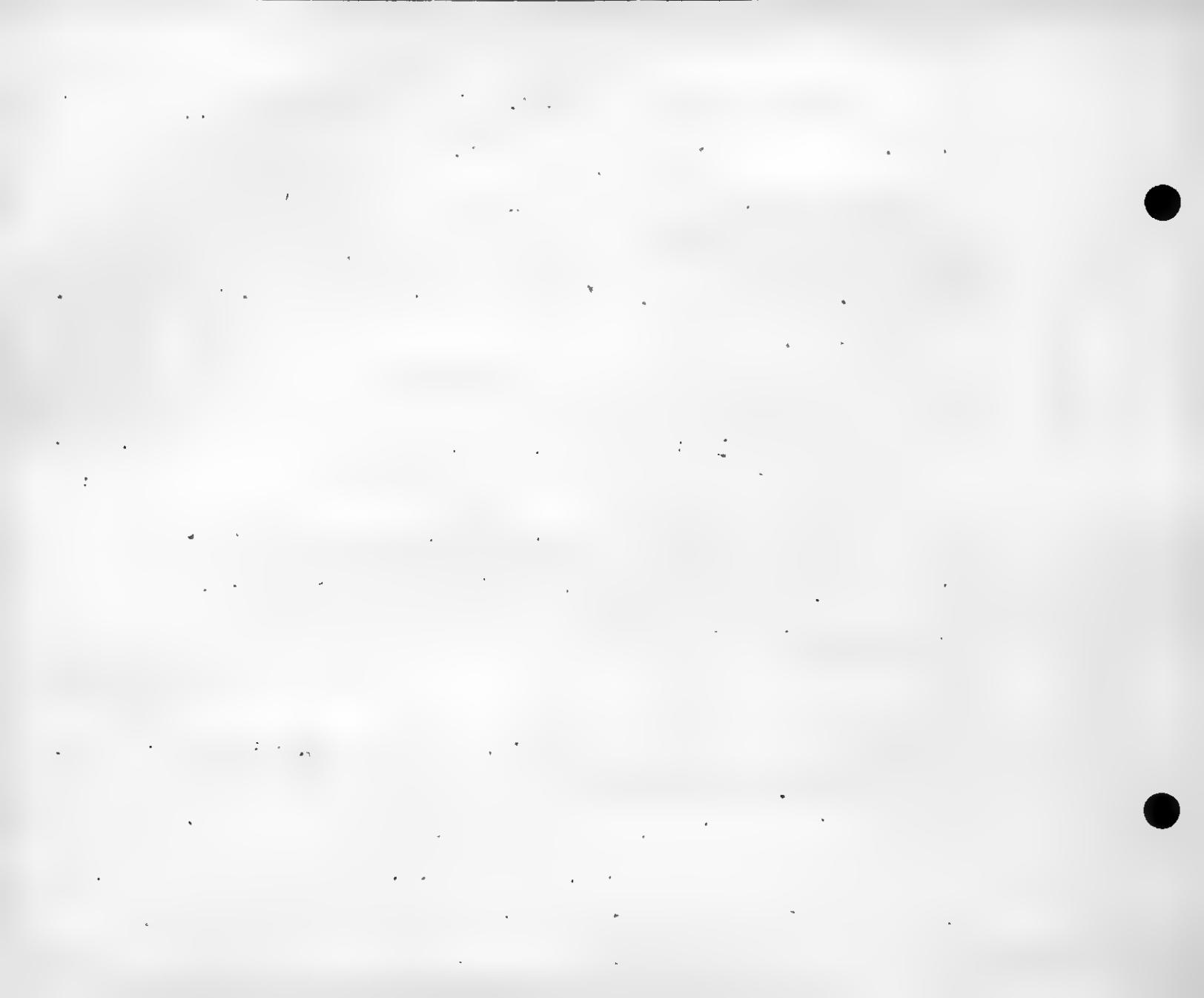
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

0321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Bertha	Middle Mae	Last Harbaugh	2a. DATE OF DEATH Month February 29, 1968 Year 1968	2b. HOUR 2 p.m.				
3. SEX female		4 RACE white		5. DATE OF BIRTH Feb. 3, 1892		6. AGE (in years last birthday) 78 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor		12a. USUAL OCCUPATION (Kind of work done during last 5 years, if working, or, even if retired) House wife		12b. KIND OF BUSINESS OR INDUSTRY				
13a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Wash.		13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 238 S. Mulberry St.				
14. FATHER'S NAME First John D. Ausherman		15. MOTHER'S MAIDEN NAME First Susan Delauder								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Joseph Miller, Hagerstown, Md.		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1778		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic Carcinoma</u>				9 mo				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Squamous Cell Carcinoma Cervix</u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Recto Vaginal Fistula due to Radiation therapy</u>										
19a. DATE OF OPERATION 12/2/67		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rectovaginal Fistula		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> , to <u>Feb 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 10, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Richard V. Hauer Jr.</u>		DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED MAR 1, 68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 247 N. Potomac St HAGERSTOWN, Md.								
23a. BURIAL, CREMATION, BURIEN (Specify)		23b. DATE 3-2-68		23c. NAME OF CEMETERY OR CEMATORIALY Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown, Md.				
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		ADDRESS Minnich Funeral Home, Hagerstown, Md.		25a. REC'D. BY REGISTRAR MAR 4 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First IDA	Middle BETTS	Last HARBAUGH	2a. DATE OF DEATH Month FEBRUARY 24 1968 Day Year 1968	2b. HOUR A.M. 1:30
3. SEX Female	4. RACE White	5. DATE OF BIRTH Dec. 9, 1887		6. AGE (in years last birthday) 80 yrs.	
7a. BIRTHPLACE (State or foreign country) Washington	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Boonsboro, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Reeder Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Work		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. US/JAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland	13b. CITY OR TOWN Washington	13c. CITY OR TOWN Smithsburg	13d. INSIDE CITY LIMIT YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER White Hall Road	
14. FATHER'S NAME George A. Betts	First Middle George A. Betts	Last	15. MOTHER'S MAIDEN NAME Florence V. Haur	Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. None	17. INFORMANT Jesse H. Harbaugh	Address Hagerstown, Md 62 E. Irvin Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instead 597		
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cerebral Vasculitis					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 9, 1968, to Feb. 9, 1968, that (I) (we) last saw the deceased alive on Feb. 9, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. W. LeVan		DEGREE ATTENDING PHYS.	22c. DATE SIGNED 2/26/68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Boonsboro, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 27, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery	23d. LOCATION (City or Town) Smithsburg	(County) Md (State)
24. FUNERAL DIRECTOR Hagerstown, Md.		ADDRESS Andrew K. Coffman Funeral Home Inc.		25a. DECEMBER REGISTRATION DATE Feb. 28, 1968	25b. DIRECTOR'S SIGNATURE John G. Coffman



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

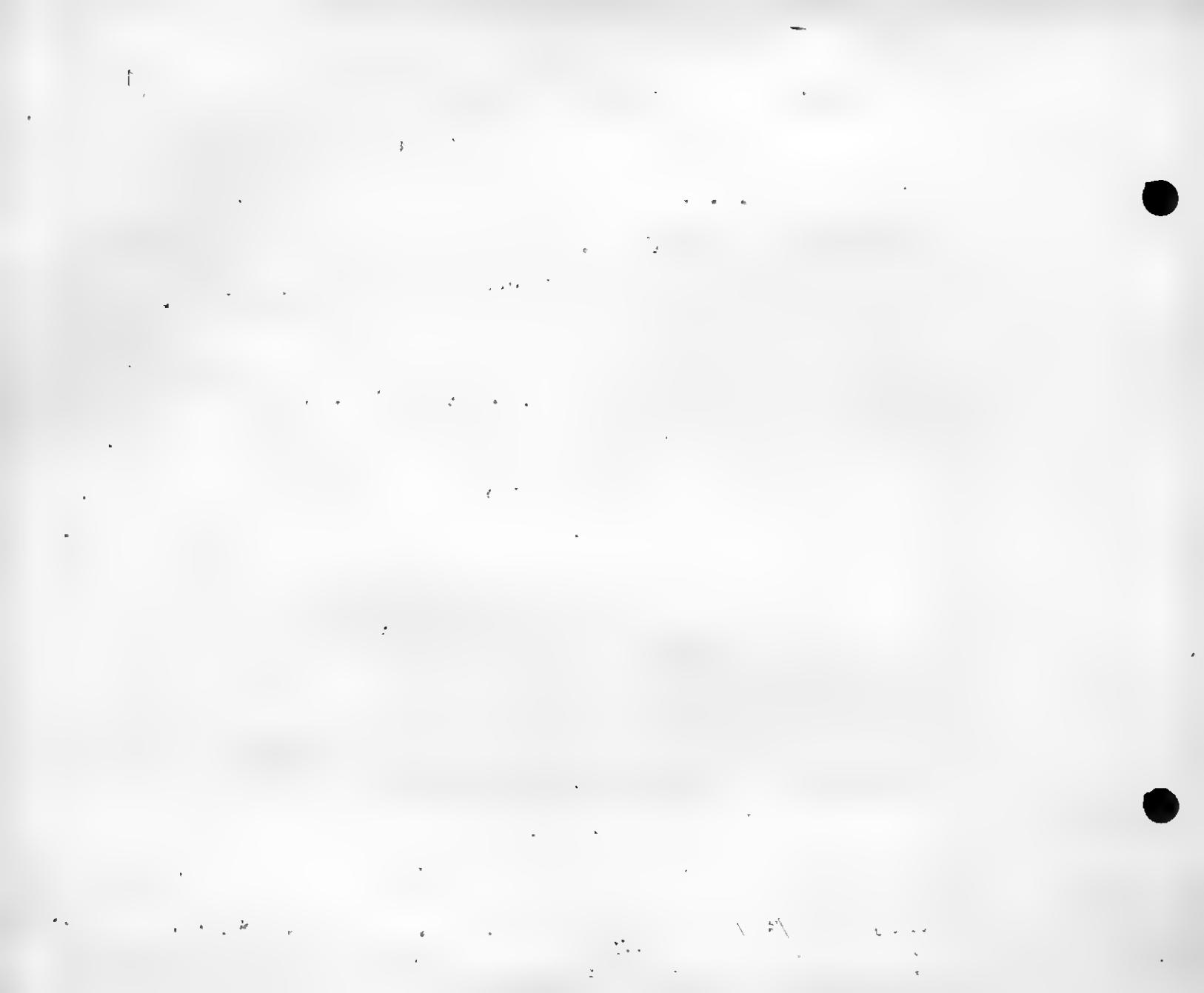
CERTIFICATE OF DEATH

1214

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)	First BELINDA	Middle CECILIA	Last HENSON	2a. DATE OF DEATH Month 2 Day 11 Year 1968	2b. HOUR 12:05			
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 7/31/1961		6. AGE (in years last birthday) 8	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON				
10. CITY OR TOWN OF DEATH MAUGANSVILLE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) NORTH ST.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) CHILD	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN MAUGANSVILLE	13d. INSIDE CITY, MHTS? <input checked="" type="checkbox"/>	13e. STREET AND NUMBER NORTH ST.				
14. FATHER'S NAME LEONARD	First L.	Middle HENSON	Last	15. MOTHER'S MAIDEN NAME ROBERTA	WEAVER			
16a. WAS DECEASED EVER Yes, no, or unknown NO	IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b. SOCIAL SECURITY NO NONE	17. INFORMANT MR. LEONARD L. HENSON	MAUGANSVILLE MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastasis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos			
19.29 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) Neuroblastoma					4 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c) Mixed Sarcoma					2 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1734								
20a. DATE OF OPERATION —		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20d. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. — Month — Day — Year 19 P.M. —		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. —	City or Town —	County —	State —	
22a. I certify that (I) (this hospital) attended the deceased from 10/31/1968 to 11/1/1968 , that (I) (we) last saw the deceased alive on 2/10/1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Richard A. Young, M.D.</i>		22c. DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22d. DATE SIGNED 2/12/68	
22e. ADDRESS Hagerstown, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 2/13/68	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Rest Haven Cem.		23d. LOCATION (City or Town) HAGERSTOWN	(County) WASHINGTON	(State) MD.		
24. FUNERAL DIRECTOR J. Norment Funeral Home	ADDRESS Hagerstown	25a. REC'D BY REGISTRAR FEB 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Young</i>				

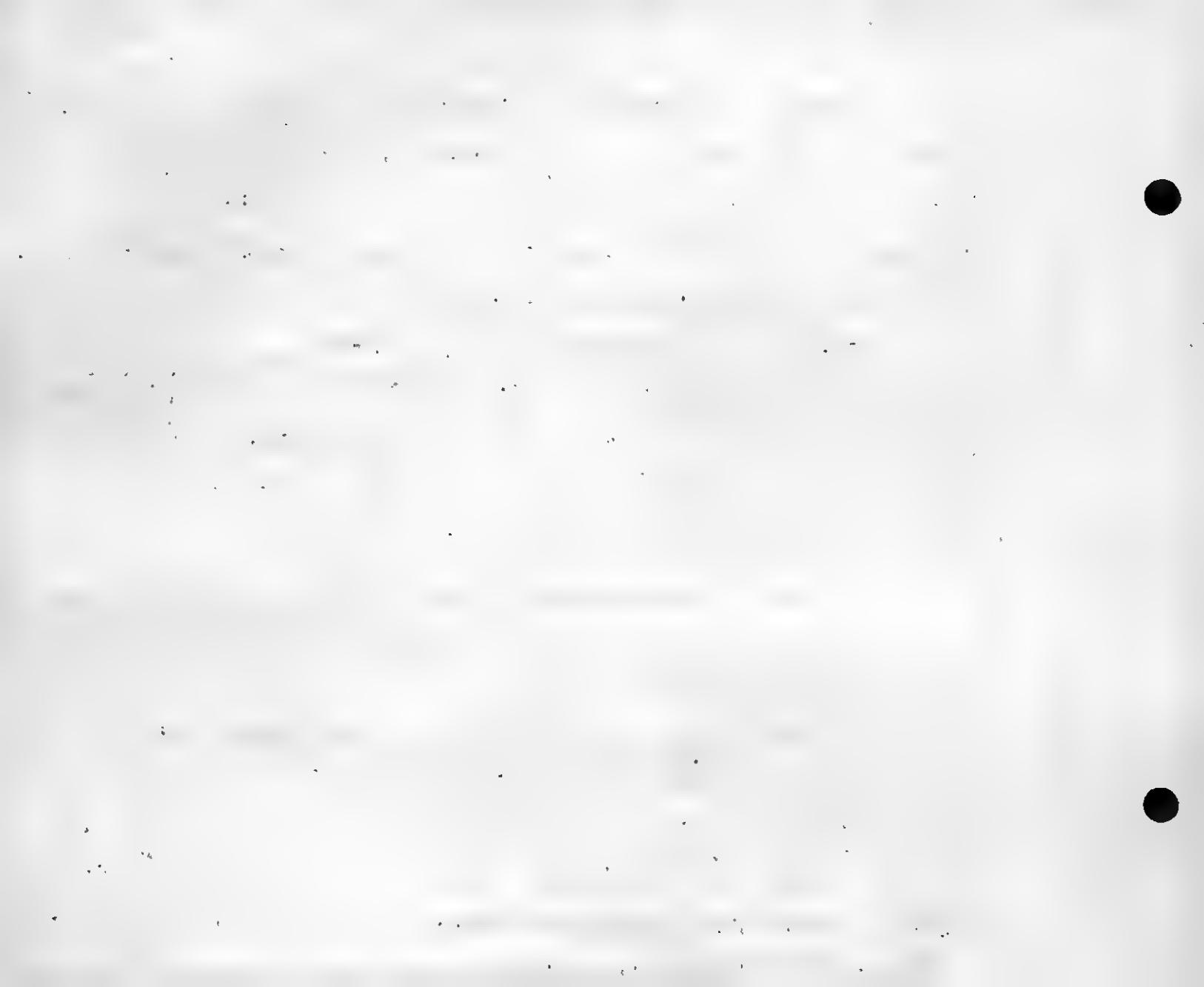


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Katherine	Middle Mercedes	Last Hetherington	2a. DATE OF DEATH Month February	Day 7	Year 1968	2b. HOUR 8:30 A.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH January 12, 1907		6. AGE (in years last birthday) 61		IF UNDER MONTHS 0	YEAR DAYS 25	IF UNDER 24 HRS. HOURS MIN. 0
7a. BIRTHPLACE (State or foreign country) Scotland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1826 Homewood Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Telephone Operator		12b. KIND OF BUSINESS OR INDUSTRY Tel. Co.		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 1826 Homewood Road				
14. FATHER'S NAME Daniel	Middle McVicker	Last 	15. MOTHER'S MAIDEN NAME Agnes	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No	16b. SOCIAL SECURITY NO. 352-01-1752	17. INFORMANT Mrs. Betty Troncatti						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction 410.9 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic Heart Disease not known Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerosis Pan. not known								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 410.9								
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Feb. Day 5 Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Stab					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Office Building	21f. LOCATION Street or R.F.D. No. 119	City or Town Hagerstown	County Washington	State Maryland		
22a. I certify that (I) (this hospital) attended the deceased from July 1967 to Feb. 5, 1968 , that (I) (we) last saw the deceased alive on Feb. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (do not) view the body after death.								
22b. SIGNATURE Armando R. Riego		DEGREE MD	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2/7/68		
22d. PHYSICIAN'S NAME (Type) Armando R. Riego		22e. ADDRESS 119-E. Antietam st.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 10, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Monongahela Cemetery	23d. LOCATION (City or Town) Monongahela, Washington, Penna.	(County) (State)			
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf Williamsport, Maryland		25a. REC'D. BY REGISTRAR DATE FEB 8 1968		25b. REGISTRAR'S SIGNATURE George				



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)	First Madge	Middle Eugina	Last Hicks	2a. DATE OF DEATH Month Feb	Day 3	Year 1968	2b. HOUR 3:30 P.M.				
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH Sept 1 1895			6. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR MONTHS 0	IF UNDER 14 HRS. DAYS 0	HOURS 0	MIN. 0	
7a. BIRTHPLACE (State or foreign country) Hagerstown Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic			12b. KIND OF BUSINESS OR INDUSTRY Private Fan				
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 409 N. Jonathan St							
14. FATHER'S NAME First Richard	Middle Brown	Last 	15. MOTHER'S MAIDEN NAME First Katy Hill	Middle 	Last 						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 217-30-6437	17. INFORMANT Miss Loretta Brown	Address 409 N. Jonathan St								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost. (b) Glomerulo sclerosis of kidneys DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus										3 weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 2/14 Y										4 months - 20 years -	
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from 1953 , 19 1968 , to 2/3 , 19 1968 , that (I) (we) last saw the deceased alive on 2/3 , 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 2/5/68	
22d. SIGNATURE George Jennings M.D.		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22e. ADDRESS 318 N. Potomac St Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-8-1968	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery			23d. LOCATION (City or Town) Hagerstown Md		(County)	(State)		
24. FUNERAL DIRECTOR NAME John R. Watson, Jr. Hagerstown, Md.		ADDRESS			25a. RECEIVED BY REGISTRAR DATE FEB 9 1968	25b. REGISTRAR'S SIGNATURE James Judge					

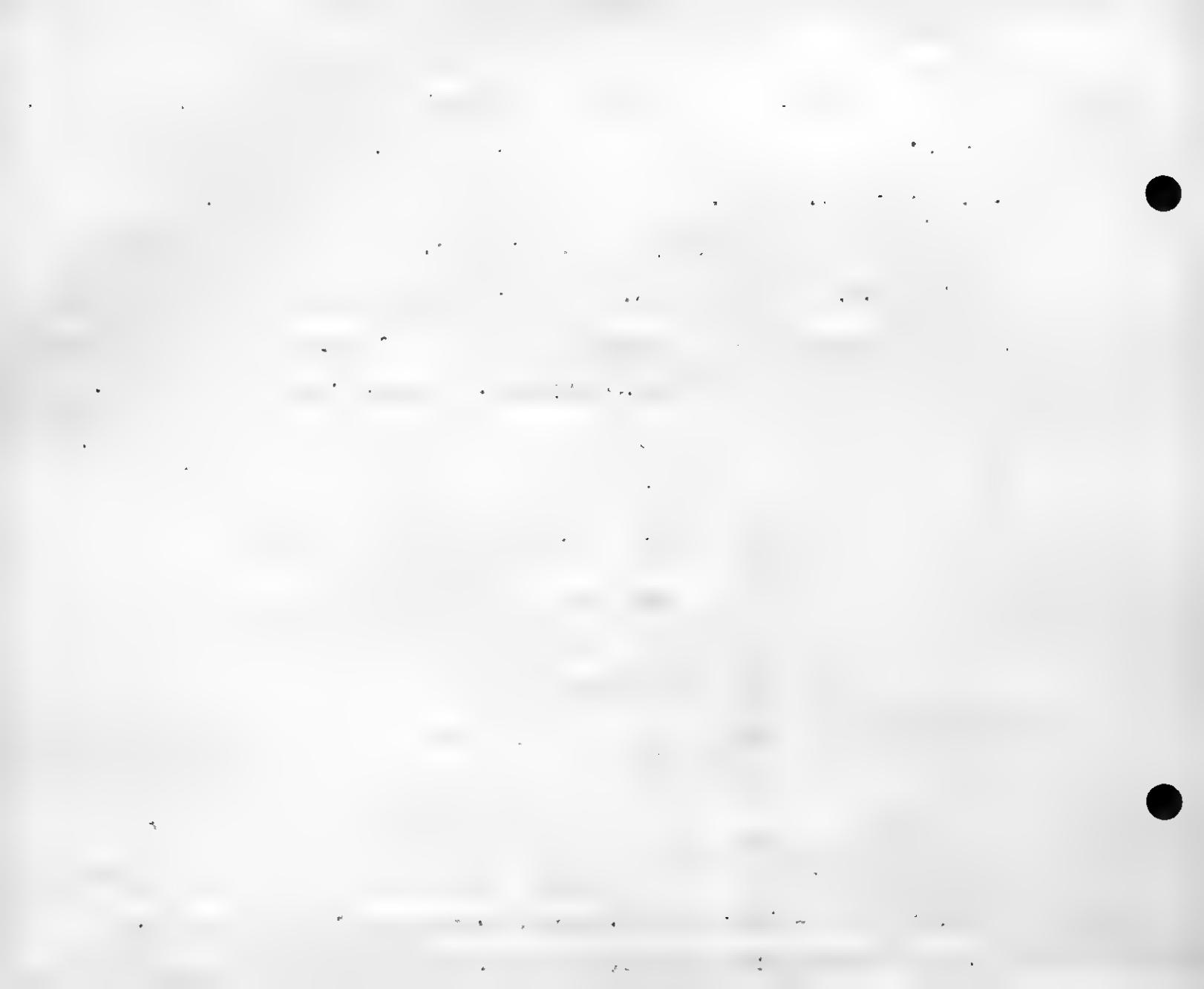


1
23234
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
03215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Nellie	Middle Spicer	Last Hiedewohl	2a. DATE OF DEATH Month 2 - Day 19 - Year 68	2b. HOUR 6:35 p.m.
3. SEX female	4. RACE white	5. DATE OF BIRTH 9-27-1884	6. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) West, Virginia.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 920 The Terrace	
14. FATHER'S NAME First Walter	Middle -	Last McDonald	15. MOTHER'S MAIDEN NAME First Theresa	Middle -	Last Jackson
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 216-22-1895	17. INFORMANT Mrs. Eleanor Robinson Hagerstown, Md.	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause hypertensive vascular disease 5 yrs.					
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis - Generalized 5 yrs +					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 Month Feb Day 19 Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from Feb 10 , 1968, to Feb 19 , 1968, that (I) (we) last saw the deceased alive on Feb 19 , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.					
22b. SIGNATURE Lloyd A. Hoffmen		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED 2/20/68
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffmen		22e. ADDRESS 214 N. Potomac St. Hagerstown, Md.			
23c. BURIAL (CREMATION, REMOVAL) (Specify) Burial		23b. DATE 2-22-68	23c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County) (State)
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 23 1968	25b. REGISTRAR'S SIGNATURE Charles J. Minnich	

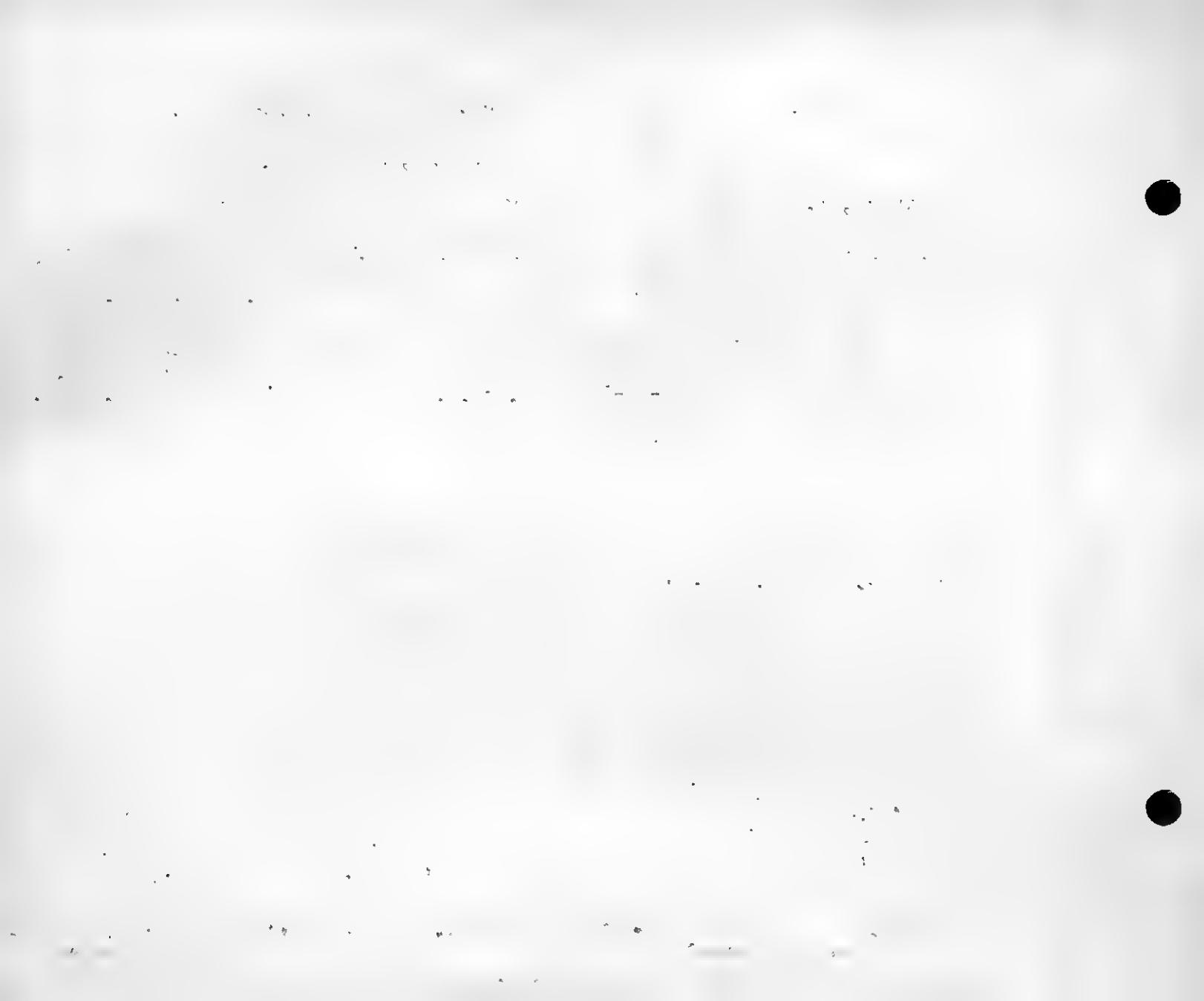


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

63235 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 5 & 6 Film G398 2/28/68 lk CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First <i>William</i>	Middle <i>Henry</i>	Last <i>Hollenbach</i>	2a. DATE OF DEATH Month <i>February</i>	Day <i>10</i>	Year <i>1968</i>	2b. HOUR <i>M</i>	
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>March 5, 1885</i>		6. AGE (In years last birthday) <i>87 81 yrs.</i>		IF UNDER 1 YEAR MONTHS <i>87</i>		
7a. BIRTHPLACE (State or foreign country) <i>Berwick, Pa.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Washington</i>		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during past of working life, even if retired) <i>Painter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Buildings</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) <i>Pennsylvania</i>	13b. COUNTY <i>Berks</i>	13c. CITY OR TOWN <i>Reading</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER <i>348 W. Douglass St.</i>				
14. FATHER'S NAME First <i>George</i>	Middle <i>Kline</i>	Last <i>Hollenbach</i>	15. MOTHER'S MAIDEN NAME First <i>Isabella</i>	Middle <i>Henrietta</i>	Last <i>Faust</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>196-07-2958</i>	17. INFORMANT <i>Mr. Geo. K. Hollenbach</i>	Address <i>Hagerstown, Md.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 480X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 483X (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Prosthetic pulmonary embolism</i>								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (I) (This hospital) attended the deceased from <i>Feb 8, 1968</i> , to <i>Feb 10, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 8, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. - at 8:00 a.m. <i>2/10/68</i>								
22b. SIGNATURE <i>L. L. Packer Jr. MD</i>	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>2/10/68</i>				
22d. PHYSICIAN'S NAME (Type) <i>L. L. Packer Jr. MD</i>	22e. ADDRESS <i>145 W. Washington St. Hagerstown, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>2/10/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Laureldeale Cemetery</i>	23d. LOCATION (City or Town) <i>Laureldeale</i>	(County) <i>Berks</i>	(State) <i>Penn.</i>			
24. FUNERAL DIRECTOR <i>John C. Horst</i>	ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>FEB 15 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



3
32236 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

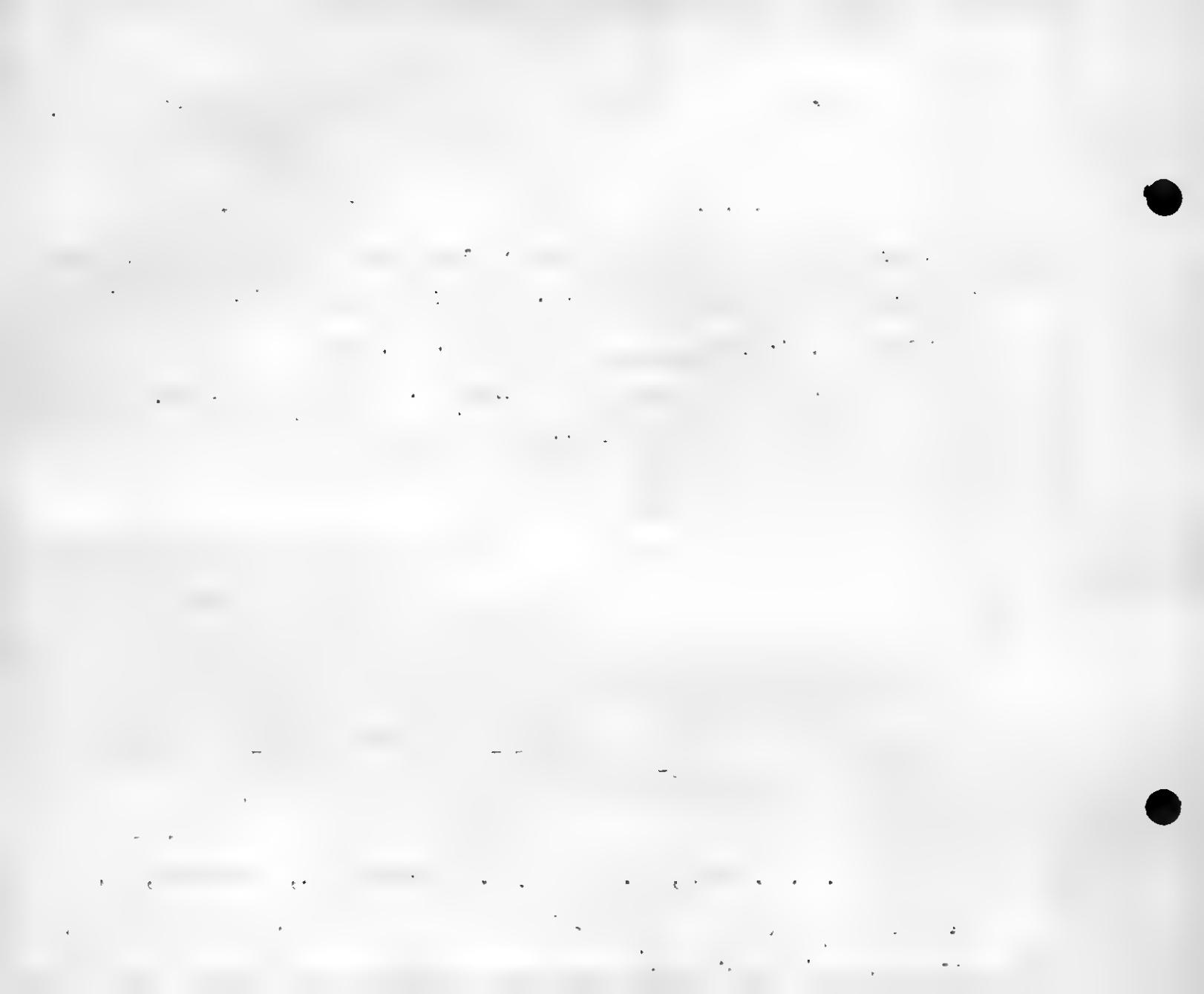
CERTIFICATE OF DEATH

3218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First BESSIE	Middle VIRGINIA	Last HOOVER	2a. DATE OF DEATH Month Feby	Day 27	Year 1968	2b. HOUR AM 9.30
3. SEX Female	4. RACE white	5. DATE OF BIRTH June 18 1877		6. AGE (in years last birthday) 90	7. IF UNDER 1 YEAR MONTHS 0		8. IF UNDER 24 HRS. HOURS 0
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH Washington	10. CITY OR TOWN OF DEATH Williamsport		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Williamsport	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 2750 Virginia Ave			
14. FATHER'S NAME First Edward F. Thomas	Middle —	Last —	15. MOTHER'S MAIDEN NAME First Annie C. Lum	Middle —	Last —		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. —	17. INFORMANT Oliver C. Hoover	Address 46 Kinship Road Baltimore Md 21222				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years					
4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) Senility DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. —	City or Town —	County —	State —		
22a. I certify that (I) (this hospital) attended the deceased from 4-9 , 19 66 , to 2-27 , 19 68 , that (I) (we) last saw the deceased alive on 2-15 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>E. W. Ditto</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 2-27-68		
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22e. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/1/68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown	(County) Wash Co	(State) Md.		
24. FUNERAL DIRECTOR Hagerstown	24b. ADDRESS Andrew K. Coffman Funeral Home Inc.	25a. REC'D BY REGISTRAR MAR 4 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Coffman</i>				



1
3237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03215

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ^{begin 1 and 2} Then please remove carbon papers. ^{begin 1 and 2} should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

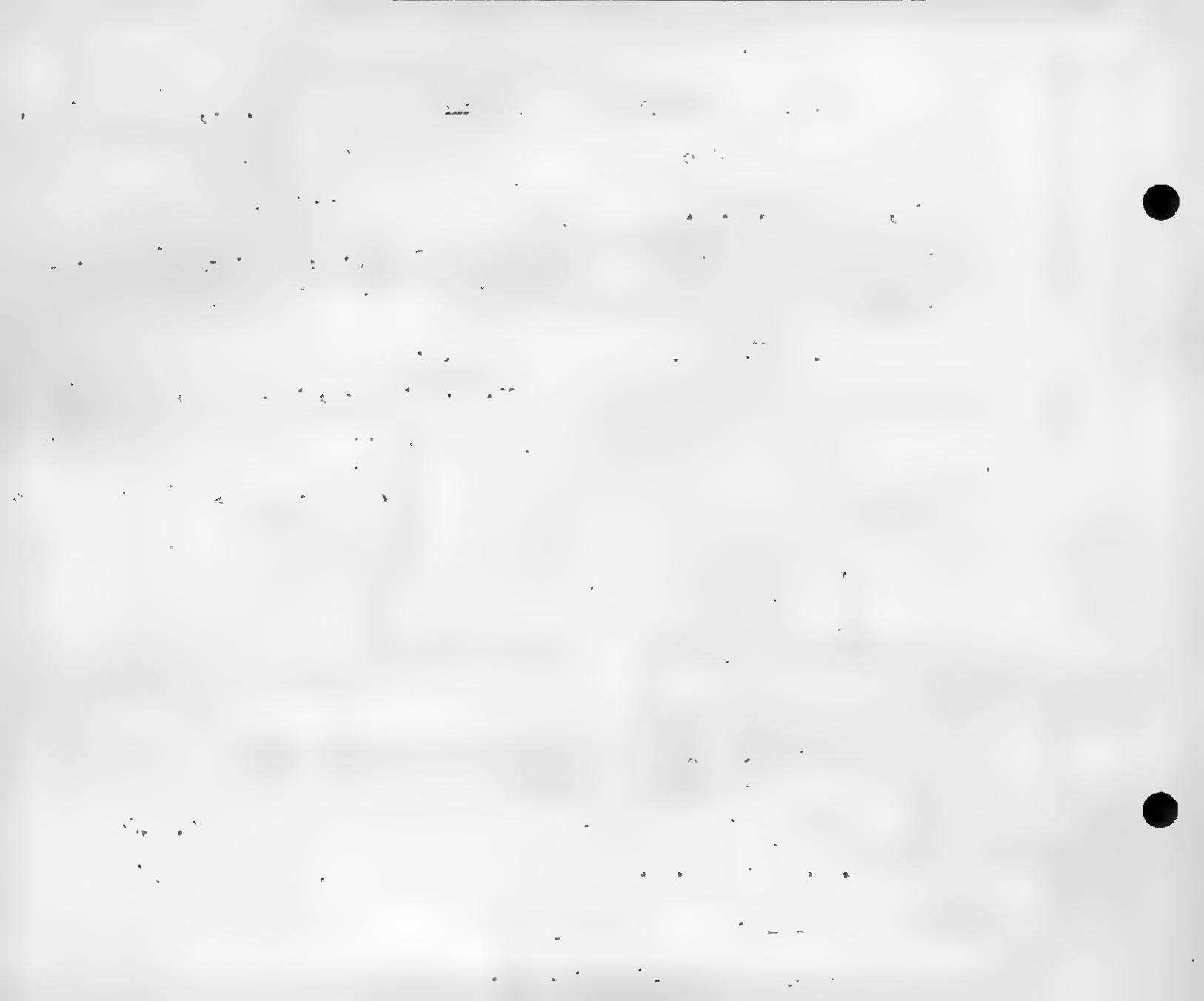
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) b. STATE					
WASHINGT ^{ON} MARYLAND		Md. WASH.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb					
Rural - Big Spring		-					
NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS					
RDI - Big Spring, Md.		RDI - Big Spring, Md.					
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First	Middle				
DOROTHY EVA HORST							
4. DATE OF DEATH		Month	Day Year				
Feb. 3, 1968							
5. SEX		6. COLOR OR RACE	7. MARRIED WIDOWED	8. NEVER MARRIED DIVORCED	9. DATE OF BIRTH	10. AGE (In years last birthday) 50 yrs.	11. IF UNDER 1 YEAR Months Days Hours Min
F. W.					1/19/1918		
10a. USUAL OCCUPATION (Give kind of work done during most of working生涯 if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Housewife		Home		MALVERN, PA.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Randall D. MALIN		Elizabeth Lehman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	
No				John A. Horst - Big Spring, Md.		Cachexia	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO Metastatic carcinoma to liver				INTERVAL BETWEEN ONSET AND DEATH 1 week	
		(c) DUE TO Colon carcinoma.				months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
10-30							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town)	(County)	(State)	
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 2-17-1968, and that death occurred at 3:30 P.M. from causes and on the date stated above.		on February 2, 1968, that (I) (we) last					
22a. SIGNATURE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 2-3-68	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		ROBERT F. READE Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORI	23d. LOCATION (City or Town)	(County)	(State)	
Burial		2/6/68	Clearspring Menn. Cem. - Clearspring, Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE		
A.C. Minich - Greencastle, Pa.				DATE FEB 6 1968	J. Charles Judge		



1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First George	Middle Christian	Last Huesman	2a. DATE OF DEATH Month Feb. 28, 1968 Day	Year 1968	2b. HOUR 12 p.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH April 25, 1882			6. AGE (in years last birthday) 85	IF UNDER 1 YEAR MONTHS YRS.
7a. BIRTHPLACE (State or foreign country) Magnolia, Del.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired Farmer		
13a. USUAL RESIDENCE (Where deceased lived, if institution before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY, J.M.TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER None		
14. FATHER'S NAME Henry C. Huesman	Middle	Last	15. MOTHER'S MAIDEN NAME No Record	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. Unknown	17. INFORMANT Mrs. Bess Huesman, Hagerstown, Maryland	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia</u>						
MEDICAL CERTIFICATION	19a. DATE OF OPERATION <u>None</u>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
	21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)	21b. TIME OF INJURY HOUR AM. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No	City or Town	County	State	
22a. I certify that (I) <u>(Bykit)</u> attended the deceased from <u>Nov. 30</u> , 19 <u>65</u> , to <u>Feb 28</u> , 19 <u>68</u> , that (I) <u>(Bykit)</u> last saw the deceased alive on <u>Feb 28</u> , 19 <u>68</u> , and that in (my) <u>(Bykit)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(Bykit)</u> <u>(did)</u> <u>(did not)</u> view the body after death.						
22b. SIGNATURE <u>M. E. Bykit</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2.29.68	
22d. PHYSICIAN'S NAME (Type) M. E. Bykit, M. D.	22e. ADDRESS Williamsport, Maryland 21795					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-2-68	23c. NAME OF CEMETERY OR CREMATORIAL Odd Fellows	23d. LOCATION (City or Town) Camden, Delaware	(County)	(State)	
24. FUNERAL DIRECTOR <u>F. E. Boultis</u>	ADDRESS Greensboro, Md.	25a. REC'D BY REGISTRAR DATE MAR 4 1968	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

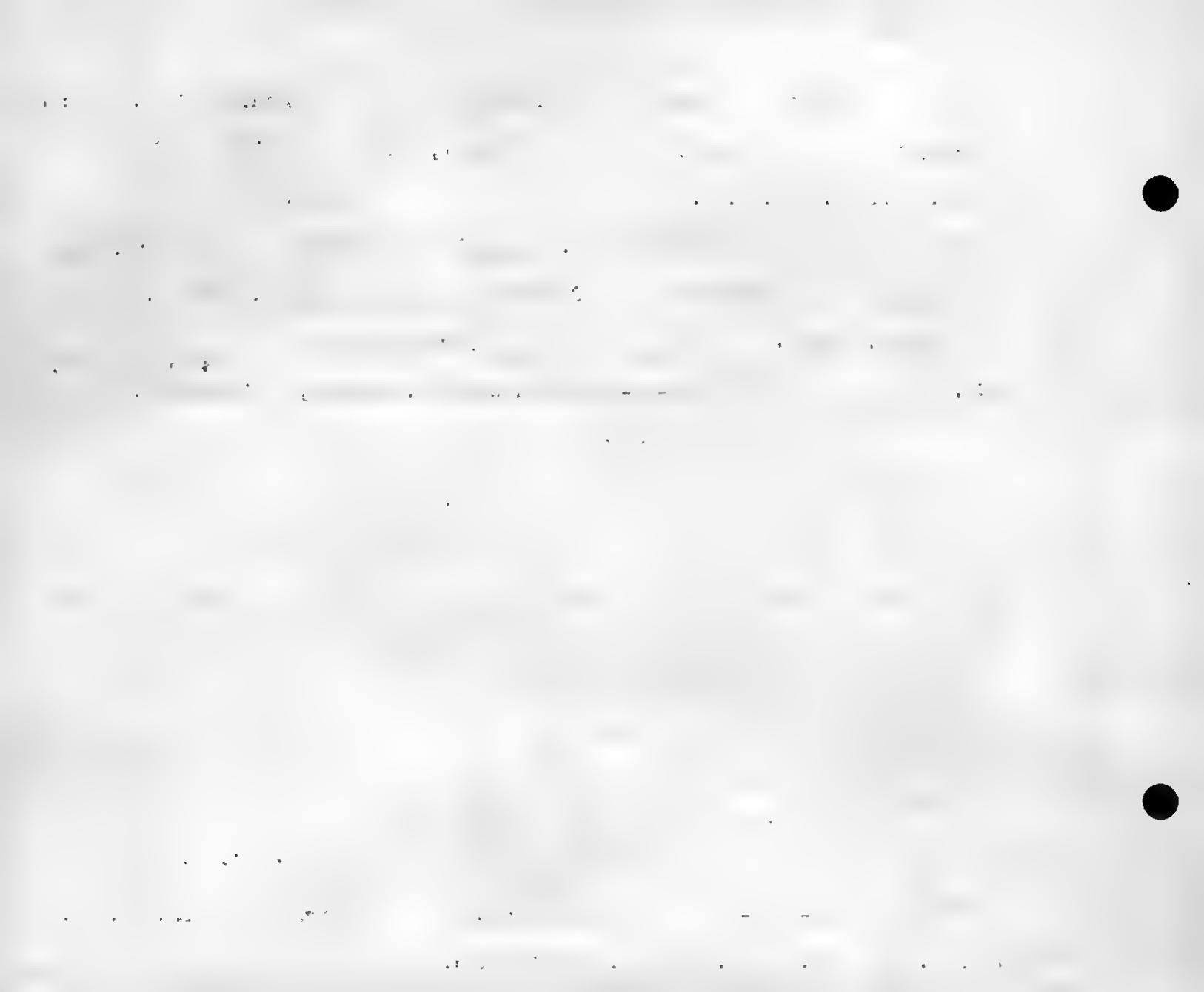


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) Martha Pearl Hutzell			2a. DATE OF DEATH Month February Day 9 1968	2b. HOUR 6:10A M			
3. SEX Female		4 RACE White	5. DATE OF BIRTH June 1, 1900	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS 8 DAYS 8	IF UNDER 24 HRS HOURS 8 MIN 0	
7a. BIRTHPLACE (State or foreign country) Wash. Co., Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 112 S. Main St.		
14. FATHER'S NAME Charles Beakley		15. MOTHER'S MAIDEN NAME Mary Easterday					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.		16b. SOCIAL SECURITY NO. 219-12-0780	17. INFORMANT Mr. Glenn E. Hutzell, 22 Young Ave.	Add Boonsboro, Md.			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>At an encroachment of cervix</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF <i>inflammation to lungs & liver</i>				4 years.	
		DUE TO, OR AS A CONSEQUENCE OF <i>(b)</i>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <u>4-9-1959</u> to <u>2-9-1958</u> , that (I) (we) last saw the deceased alive on <u>2-9-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph Secondari</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 2-10-68		
22d. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI		22e. ADDRESS Boonsboro Md.					
23a. BURIAL, CREMATION, BONE (Specify) Burial		23b. DATE 2-11-68	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co. Md.			
24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR DATE Feb 14 1968	25b. REGISTRAR'S SIGNATURE		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

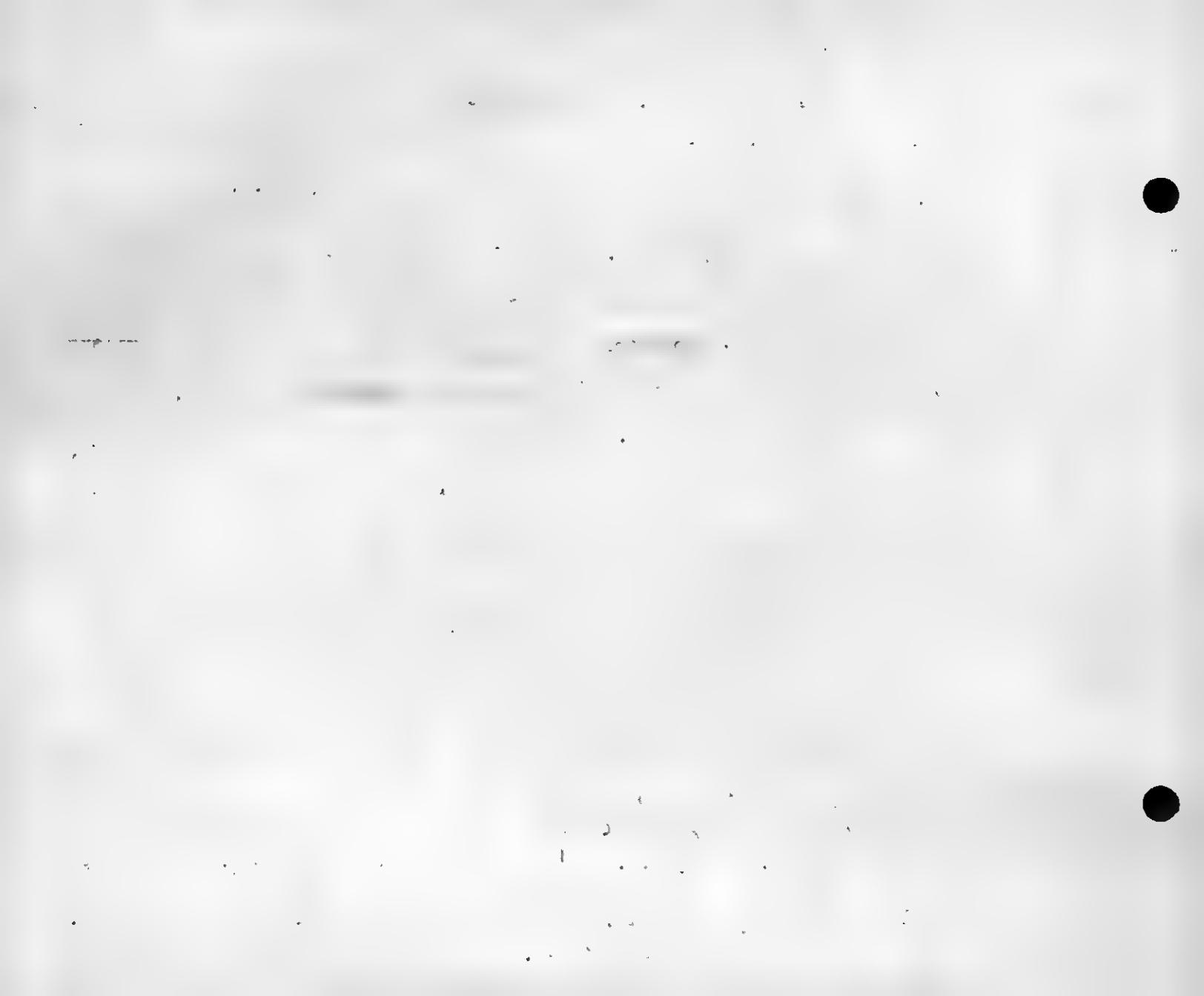
CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and 2 pages and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. DECEASED NAME (Type or print) First Charles			Middle T.	Last Johnston	2d. DATE OF DEATH 2 Month 18 Day 68 Year 11:20 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH 9/13/97		6 AGE (In years lost birthday) 70	F UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Porter	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Allegany	13c. CITY OR TOWN Nikep	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 100 W. Main St., Hagerstown, Md.
14. FATHER'S NAME James	First H.	Middle Johnston	Last Anna	Middle Hileman	Last Hileman
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO 16L-10-3136	17. INFORMANT Johnston	Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1810 <u>1 hr.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute gastric dilatation</u> ? DUE TO, OR AS A CONSEQUENCE OF (c) <u>Carcinoma of kidney</u> 1 yr. DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Metastatic carcinoma to the spine					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>7/11</u> , 19 <u>67</u> , to <u>2/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Edwin G. Riley</u>	DEGREE ATTENDING PHYS.	<input type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 2/19/68	
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley, M.D.	22e. ADDRESS Western Md. State Hospital, Hagerstown		Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) in	23b. DATE 2/20/68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. View	23d. LOCATION (City or Town) Moscov Mills	(County) Allegheny	(State) Md.
24. FUNERAL DIRECTOR <u>Ed G. Riley</u>	ADDRESS Westernport, Md.	25a. REC'D BY REGISTRAR FEB 21 1968	25b. REGISTERED SIGNATURE <u>Ed G. Riley</u>		

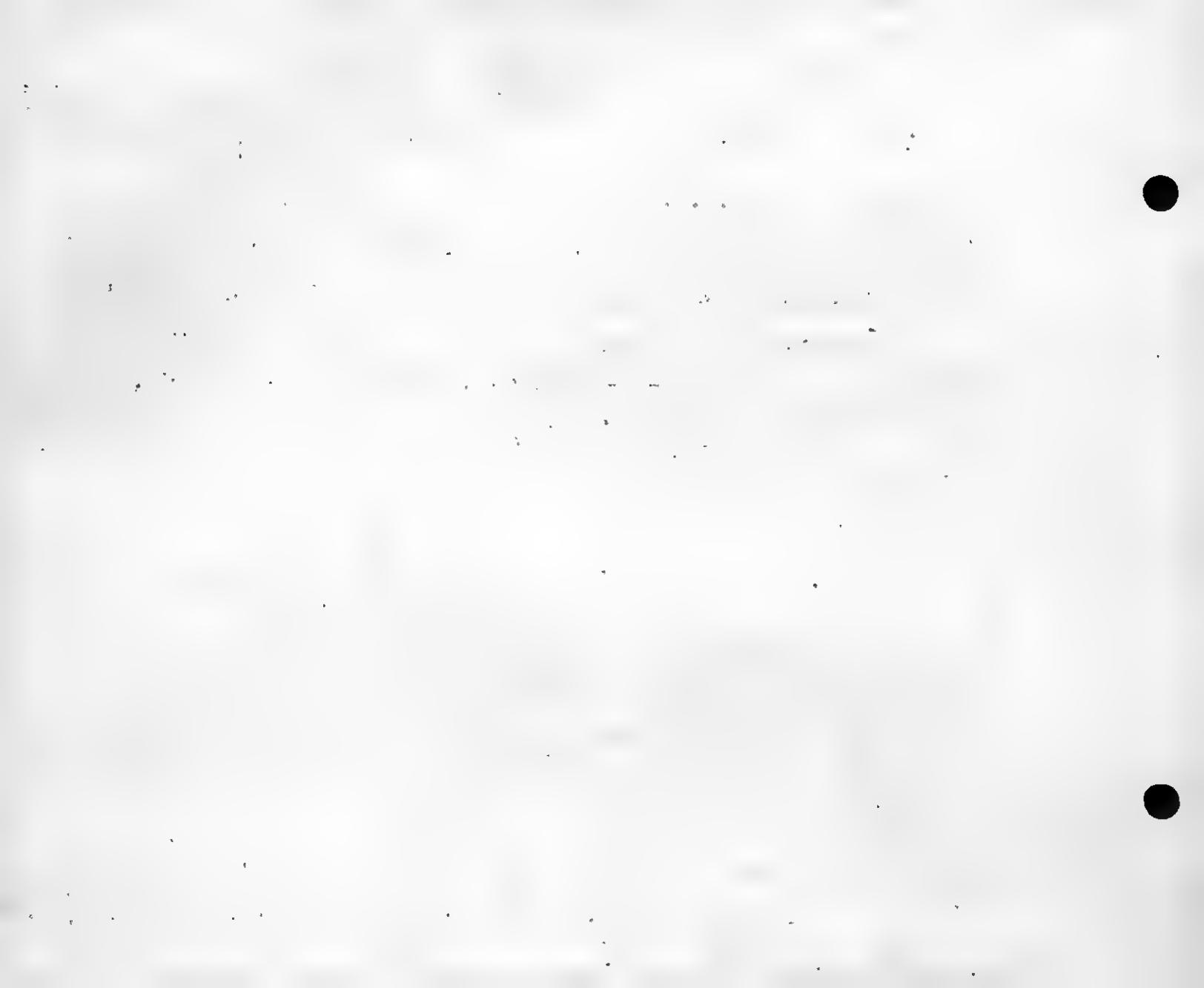


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 3241				122.1				
1. DECEASED-NAME (Type or print)		First PETER	Middle JUCHA	2a. DATE OF DEATH Month FEBRUARY 16 1968		2b. HOUR 6:00 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1/18/1887		6. AGE (In years last birthday) 81 YRS.		
7a. BIRTHPLACE (State or foreign country) POLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL				12a. USUAL OCCUPATION (Kind of work done or last of working life if retired.) MINER		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 27 WYNWOOD DRIVE		
14. FATHER'S NAME FRANK		Middle JUCHA	Last	15. MOTHER'S MAIDEN NAME MARY		Middle SZYDOWSKA	Last HAGERSTOWN MD.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 234-09-0480A		17. INFORMANT MRS. MILDRED CHAPA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> <u>4868</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>490x</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)</p>								
<p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Pulmonary Embolus & Chronic Pulmonary Disease</u></p>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>2/12</u>, 19<u>68</u>, to <u>2/16</u>, 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>2/16</u> 19<u>68</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input checked="" type="checkbox"/> (did) (did not) view the body after death.</p>								
22b. SIGNATURE <u>William O. Rexrode</u>		DEGREE ATTENDING PHYS.	22c. MED. DIRECTOR <input checked="" type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <u>2/17/68</u>		
22d. PHYSICIAN'S NAME (Type) <u>William O. Rexrode</u>		22e. ADDRESS <u>145 S. Prospect St. Hagerstown</u>						
23a. BURIAL, CREMATION, BURIAL Cremation		23b. DATE 2/20/68	23c. NAME OF CEMETERY OR CREMATORIAL MT. ROSE CEMETERY		23d. LOCATION (City or Town) MOUNDSVILLE MARSHALL W. VA		(County) (State)	
24. FUNERAL DIRECTOR <u>W. T. Ferment, Hagerstown, Md.</u>		25a. RECEIVED BY REGISTRAR DATE FEB 21 1968						25b. FINGERPRINTS SIGNATURE <u>W. T. Ferment, Hagerstown, Md.</u>



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33242MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Madge	Middle Ruth	Last Kent	2a. DATE OF DEATH Month Feb	Day 11	Year 68	2b. HOUR 30 PM
3. SEX Female	4. RACE Colored	5. DATE OF BIRTH May 30 1913		6. AGE (In years last birthday) 54	IF UNDER 1 YEAR MONTHS YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Hagerstown Md. USA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 18 W. Bethel Street			
14. FATHER'S NAME William	Middle Keys	15. MOTHER'S MAIDEN NAME Mary Whalen			Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. 214-09-0642	17. INFORMANT Mrs. Vivian Gaines, 18 W. Bethel St.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Coronary Occlusion</u>		APPROXIMATE INTERVAL BEWEEN ONSET AND DEATH repeated over 15 min. time		1 hour	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Probable massive cerebro-vascular accident.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Sat Feb 10, 1968</u> , to <u>Sun Feb 11 1968</u> , that (I) (we) lost saw the deceased alive on <u>Sun Feb 11 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>William T. Layman, M.D.</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Feb 14 '68		
22d. PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		22e. ADDRESS 100 Prof. Arts Bldg. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-15-1968	23c. NAME OF CEMETERY OR CEMINATORY Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown	(County) Md.	(State)	
24. FUNERAL DIRECTOR <u>John R Watson Jr. Hagerstown Md.</u>	ADDRESS		25a. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>John R. Watson Jr.</u>			DATE FEB 16 1968



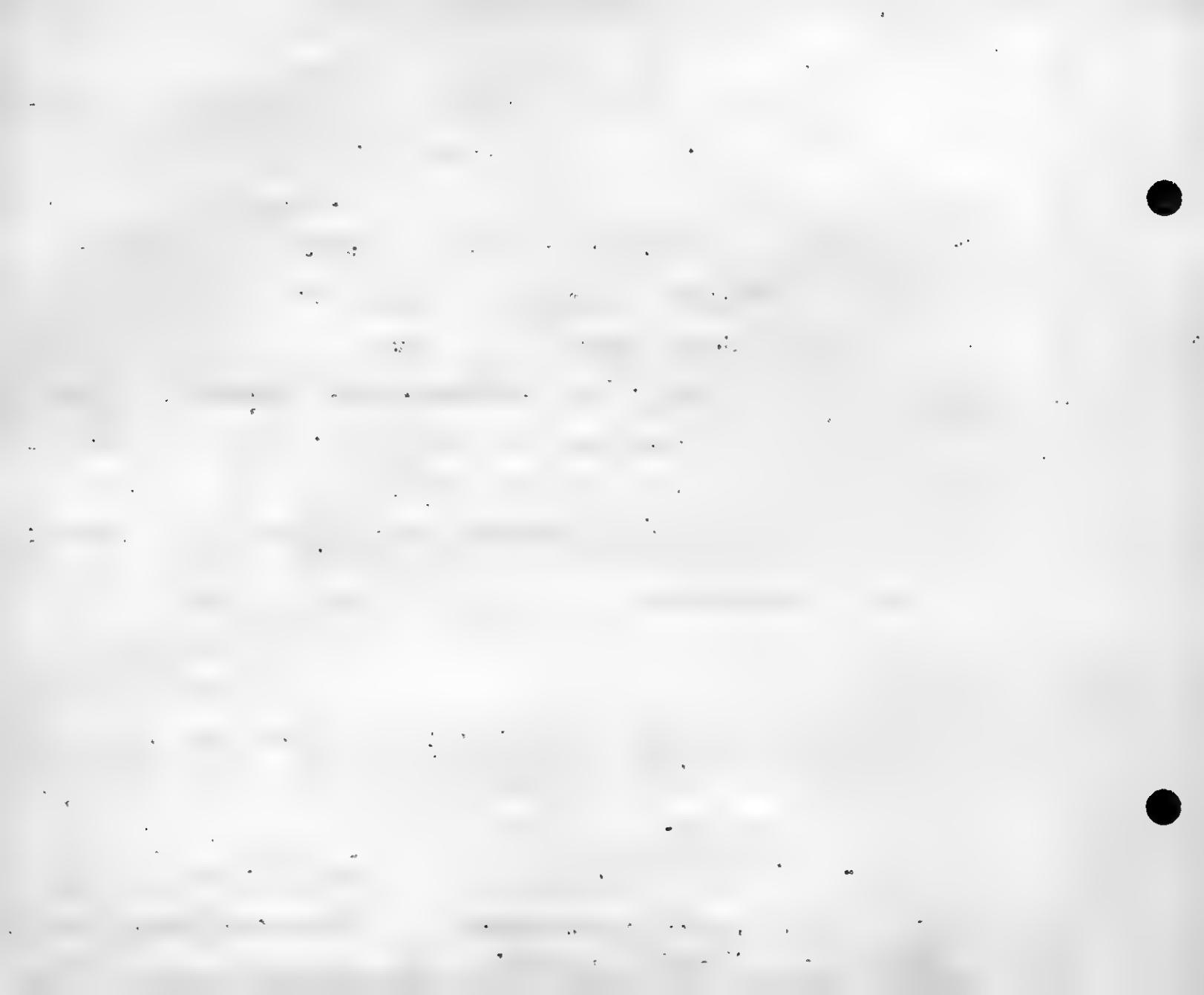
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Fannie	Middle Mae	Lost Kershner	2a. DATE OF DEATH Month February Day 8 , 1968	2b. HOUR 5:30 P.M.		
3. SEX Female		4 RACE White	5. DATE OF BIRTH December 9, 1883		6. AGE (in years last birthday) 84 YRS	IF UNDER MONTHS 1	YEAR DAYS 29	IF UNDER 24 HRS. HOURS MIN. 00
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			12b. KIND OF BUSINESS OR INDUSTRY At Home
10. CITY OR TOWN OF DEATH Rural-Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic			12b. KIND OF BUSINESS OR INDUSTRY At Home
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY J.M.T.P? YES	13e. STREET AND NUMBER 252 Hager Street			
14. FATHER'S NAME First Millard Middle Fillmore Lost Kershner		15. MOTHER'S MAIDEN NAME First Middle Susan Ida Rowe						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 220-44-9882	17. INFORMANT Miss Susan Kershner	Address 252 Hager Street Hagerstown, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7/29 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Brachopneumonia - Terminal		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis / heart Disease.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
DUE TO, OR AS A CONSEQUENCE OF (c) Cirterio sclerosis, generalized and cerebral		10 years.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 19 Month Day Year P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6/19/57 , 19 68 , to 2/18 , 19 68 , that (I) (we) last saw the deceased alive on 2/1/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE George Jennings		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 2/9/68			
22d. PHYSICIAN'S NAME (Type) George Jennings		22e. ADDRESS 316 N. Potowmack St Hagerstown						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 11, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery		24d. LOCATION (City or Town) Williamsport, Wash.	(County) Maryland	(State)	
24. FUNERAL DIRECTOR Albert L. Leaf		ADDRESS Williamsport, Maryland	25a. REGD-BY REGISTRAR Feb 13 1968		25b. REGISTRAR'S SIGNATURE			



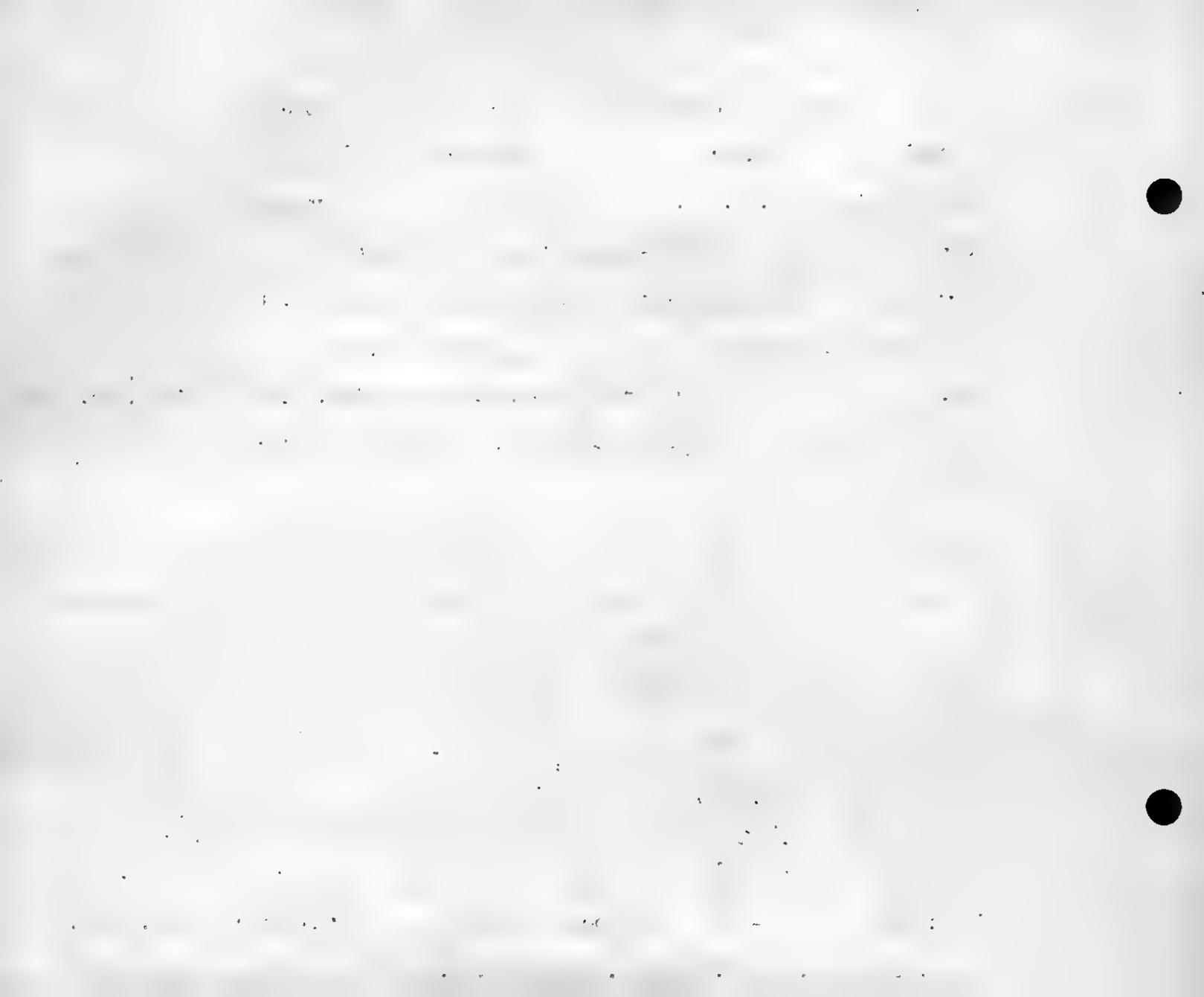
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Julia	Middle Catherine	Lost Kline	2a. DATE OF DEATH Month February	Day 4	Year 1968	2b. HOUR 9:30PM		
3. SEX Female	4 RACE White	5. DATE OF BIRTH October 23, 1876		6. AGE (in years last birthday) 91		7. IF LNDER 1 YEAR MONTHS 3		8. IF LNDER 24 HRS. HOURS 11	
7a. BIRTHPLACE (State or foreign country) Relay, Virginia	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington						
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairney- Keedy Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR IND.STRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY, J.M.T.S? YES	13e. STREET AND NUMBER Rfd. 1					
14. FATHER'S NAME Josiah Mullendore	First Middle Last	15. MOTHER'S MIDDLE NAME Meriah Rohrer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. 212-14-7029	17. INFORMANT Mr. C. Edwin Kline, Silver Springs, Md. 20910							
9200 Harvey Rd. Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs								
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Arterosclerosis with senility DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 731									
19a. DATE OF OPERATION 7/21	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State				
22a. I certify that (I) (this hospital) attended the deceased from July 10, 1967 , to Feb 7, 1968 , that (I) (we) last saw the deceased alive on Feb 7, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE G. W. Van	22c. DEGREE ATTENDING PHYS.	22d. ADDRESS Boonsboro, Md.	22e. MED. DIRECTOR <input checked="" type="checkbox"/>	22f. STAFF PHYS. <input type="checkbox"/>	22g. DATE SIGNED Feb 6, 1968				
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment	23b. DATE 2-7-68	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Mausoleum	23d. LOCATION (City or Town) Boonsboro, Wash. Md.	(County)	(State)				
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE FEB 7 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...					
VR A15 (4) 30M REV 1/68									



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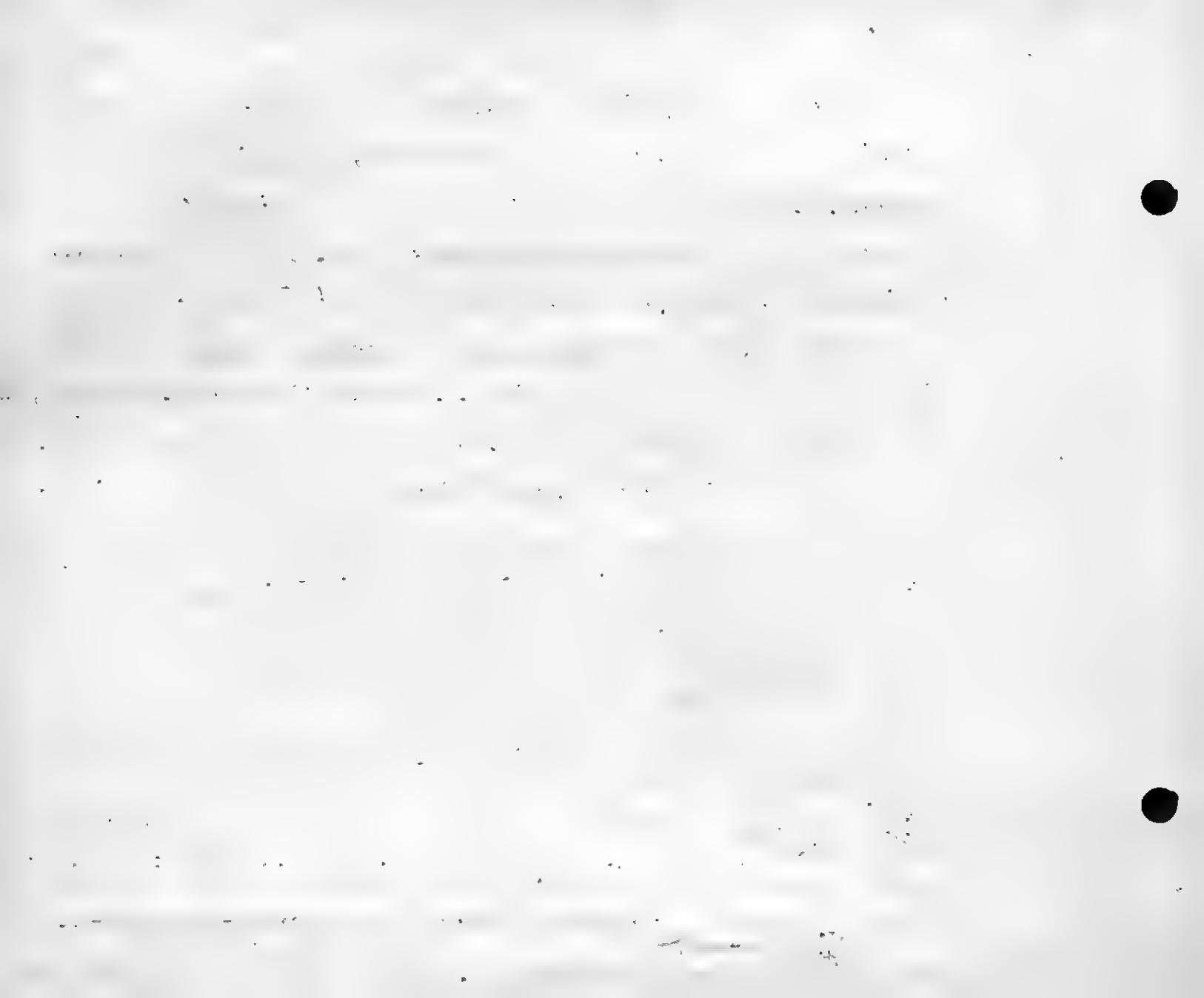
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

11322

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 2 and 3) and return this certificate, along with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Mary</i>	Middle <i>Julia</i>	Last <i>Lancaster</i>	20. DATE OF DEATH Month <i>February</i>	Day <i>15</i>	Year <i>1968</i>	2b. HOUR <i>5:50 A.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>	5. DATE OF BIRTH <i>September 28, 1880</i>		6. AGE (In years last birthday) <i>87</i>		7. UNDERR 1 YEAR MONTHS <i>87</i>		8. UNDERR 24 HRS DAYS <i>0</i>		
7a. BIRTHPLACE (State or foreign country) <i>Paw Paw, W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Washington</i>					
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13c. CITY OR TOWN <i>Washington</i>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>1037 View St.</i>					
14. FATHER'S NAME First <i>William</i>		Middle <i>Thomas</i>	Last <i>Humphrey</i>	15. MOTHER'S MAIDEN NAME First <i>Elizabeth</i>		Middle <i>Ellen</i>	Last <i>Rother</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT		Address <i>Miss H. E. Lancaster 1037 View St. Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Insufficiency</i>								48 hrs.			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Atherosclerotic Heart Disease</i>								10 yrs.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>last. 4201</i>											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Volvulus and strangulated inguinal hernia - 5 days post-op.</i>											
19a. DATE OF OPERATION <i>Feb 10 '68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Part 2 above.</i>		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>City or Town</i> County <i>State</i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 9, 1968</i> , to <i>Feb 15, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb 15, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>William T. Layman, M.D.</i>		22c. DATE SIGNED <i>Feb 16 '68</i>									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <i>100 Prof. Arts Bldg. Hagerstown, Md. 21740</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2/19/68</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) <i>Hagerstown-Washington Md.</i>		(County) <i>Hagerstown</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>W. C. Horn</i>		ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REG STRR <i>DATE 6 21 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

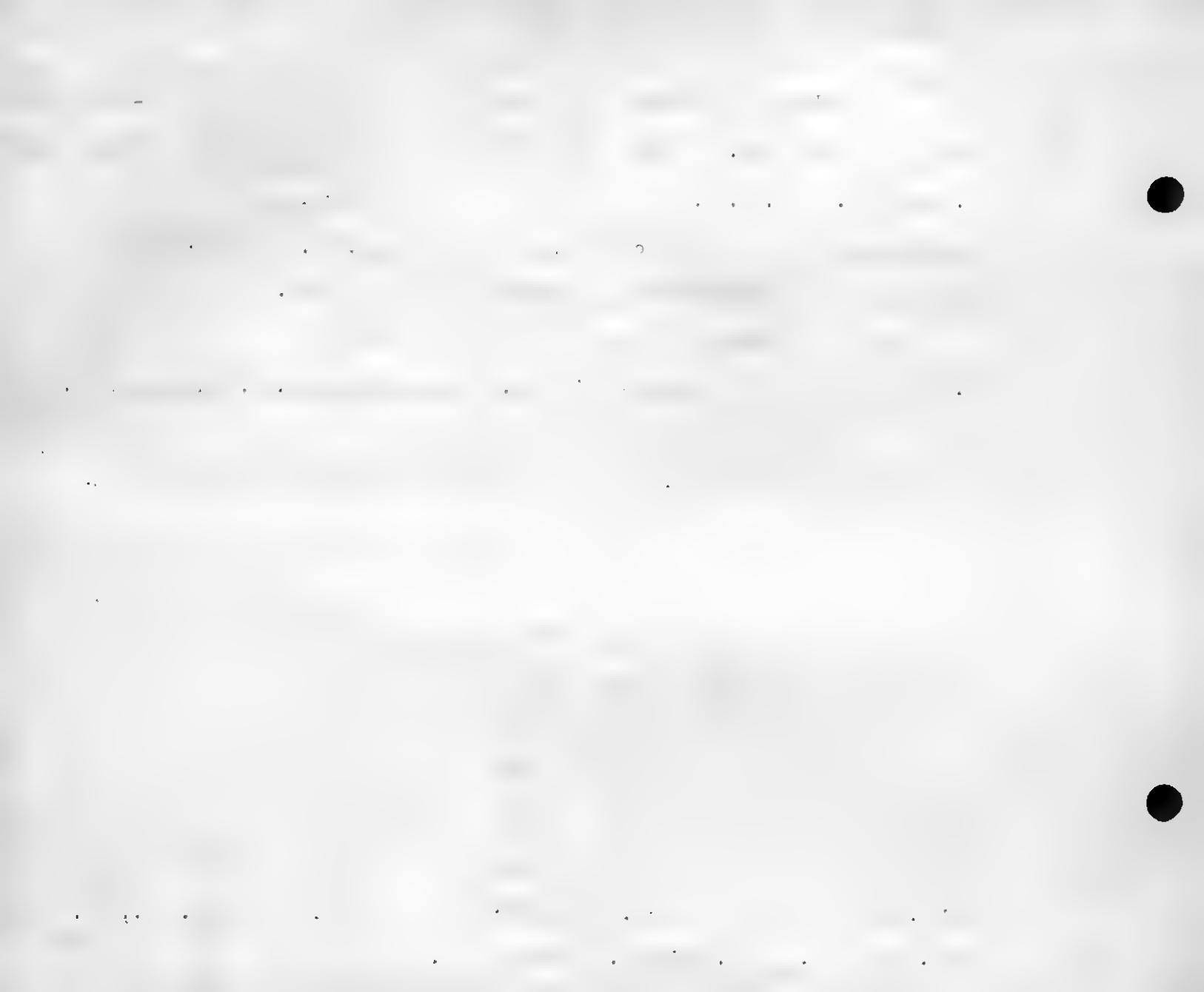
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if any delay is necessary, please execute the certificate, writing the word "Pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

65246

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First William	Middle Oscar	Lost Lum	2a DATE KNOWN OF ESTI DEATH MATED <input type="checkbox"/>	Month 2	Day 20	Year 1968	2b HOUR 12:00
3 SEX Male	4 RACE White	5 DATE OF BIRTH Nov. 28, 1900	6 AGE (In years last b'mday) 67 YRS	IF UNDER 1 YEAR 2 MONTHS	IF UNDER 24 HRS 22 DAYS	IF HOURS 0 MIN	2c DATE PRONOUNCED DEAD Month February		
7a BIRTHPLACE (State or foreign country) Mt. Lena, Md.		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8 MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	W DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH Washington		2d HOUR 10:15
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Public Square			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Wash. Co. Constable			12b KIND OF BUSINESS OR INDUSTRY Co. Police	
13a USUAL RESIDENCE (Where deceased lived, if institution of residence) Maryland		13b COUNTY Washington	13c CITY OR TOWN Boonsboro	13d INSIDE CITY LIMITS? YES	13e STREET AND NUMBER Rfd. 2				
14 FATHER'S NAME John		First Alvey	Middle Lum	15 MOTHER'S MAIDEN NAME Minnie				16 Middle 17 Lost	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16b SOCIAL SECURITY NO (If yes give war or dates of service) 219-07-3315		17 INFORMANT Mrs. Virginia Lum, Rfd. 2, Boonsboro, Md.	ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF hypertensive arteriosclerotic disease years (b) hypertensive arteriosclerotic disease years DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a MEDICAL CERTIFICATION DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No City or Town County State						
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									22b DATE SIGNED 2/21/68
ACTUAL SIGNATURE <i>Howard N. Weeks, M.D.</i>		EXAMINER'S NAME (Type) Howard N. Weeks, M.D.			CHIEF MEDICAL EXAMINER M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	580 Northern Ave. ADDRESS (Street, city, town or county) Hagerstown, Md.
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2-23-68	23c NAME OF CEMETERY OR CREMATORIAL Mt. Lena Cemetery			23d LOCATION (City or Town) Mt. Lena Wash. Co., Md.	(County)	(State)	
24 FUNERAL DIRECTOR <i>John H. East, Jr.</i>		ADDRESS 112 N. Main St. Boonsboro, Md.			25a REC'D BY REGISTRAR FEB 26 1968	25b REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>			



FOR STATE
HEALTH DEPT.

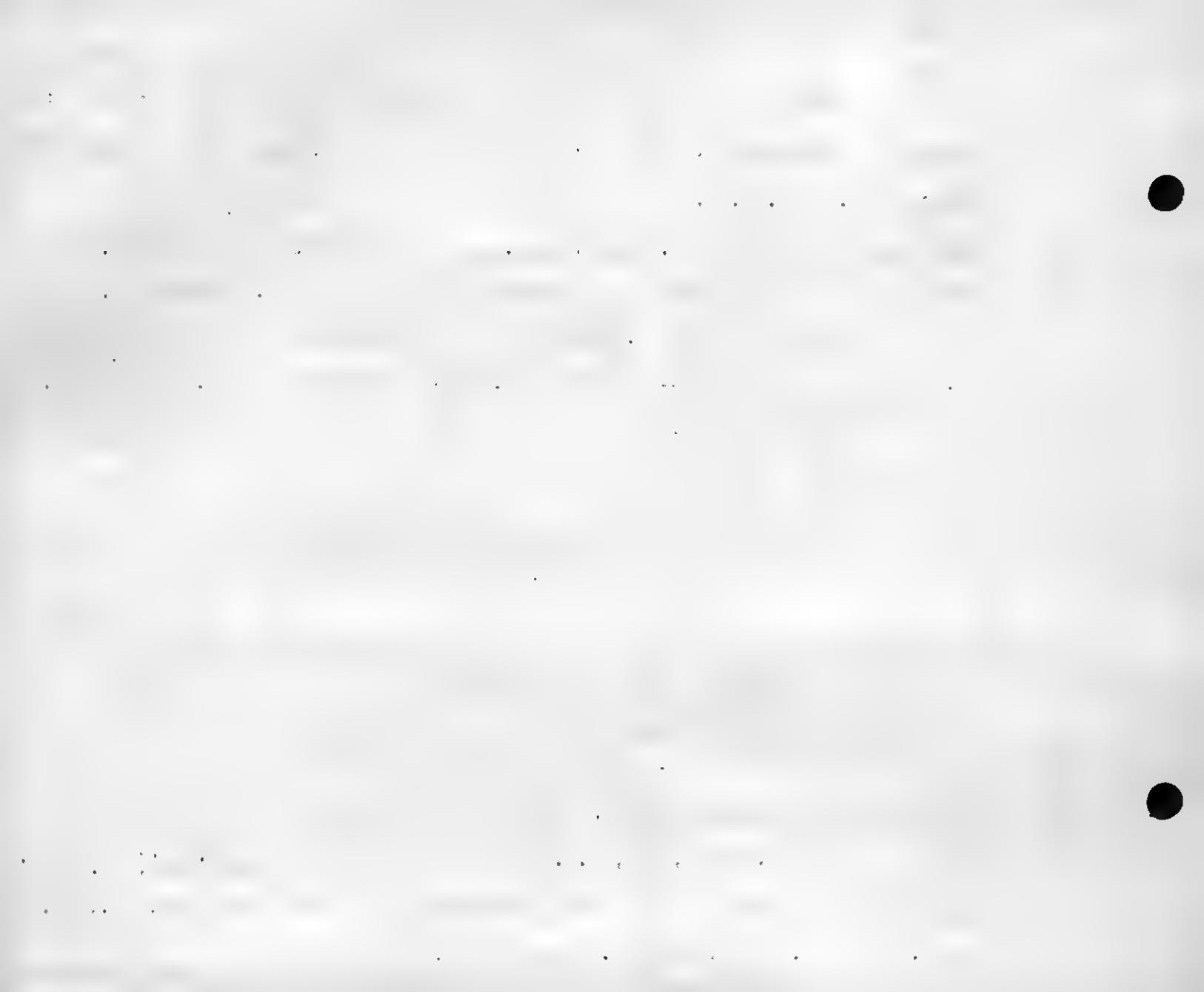
10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Virgie	Middle Ellen	Last Marteney	LOST	2a DATE KNOWN OF EST- DEATH MATED	Month 2- 25- 1968	Day 3:00P M	2b HOUR
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 IF UNDER 1 YEAR MONTHS 89	8 IF UNDER 24 HRS DAYS 24	9 MIN.	2c DATE PRONOUNCED DEAD Month February	Day 25	10a 2d HOUR Year 1968	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH				
Funkstown, Md.		U. S. A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
Funkstown			12 W. Chestnut St.			Sales Clerk			Dept. Store	
13a USUAL RESIDENCE (Where deceased lived, if institution Reside before admission), STATE			13b. COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER			
Maryland			Washington		Funkstown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	12 W. Chestnut St.			
14 FATHER'S NAME			First John	Middle Gimple	Last	15 MOTHER'S MAIDEN NAME	First Margaret	Middle	Last Rhodenizer	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO (If yes give war or dates of service) No.		17 INFORMANT	ADDRESS			Funkstown, Md.	
			214- 09- 0890		Mrs. Blenda Stottlemeyer, 12 W. Chestnut St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause b) <u>Postcardiac occlusive heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF c) <u>Adv. generalized arteriosclerosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Terminal
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Acute viral upper Respiratory tract infection</u>										10 year 25 year
19a MEDICAL CERTIFICATION			19b DATE OF OPERATION			19c CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										22b DATE SIGNED 2/26/68
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Edward W. Ditto, III, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md.				
23a. BURIA, CREMATION, REMOVAL (Specify)			23b. DATE 2- 28- 68			23c. NAME OF CEMETERY OR CREMATORIUM Funkstown Cemetery			23d. LOCATION (City or Town) (County) (State) Funkstown Wash. Co., Md.	
24 FUNERAL DIRECTOR			ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.			25a. REC'D BY REGISTRAR DATE FEB 28 1968			25b. REGISTRAR'S SIGNATURE Charles J. Jones	
VR A15ME (5) TOM REV 1/68										



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

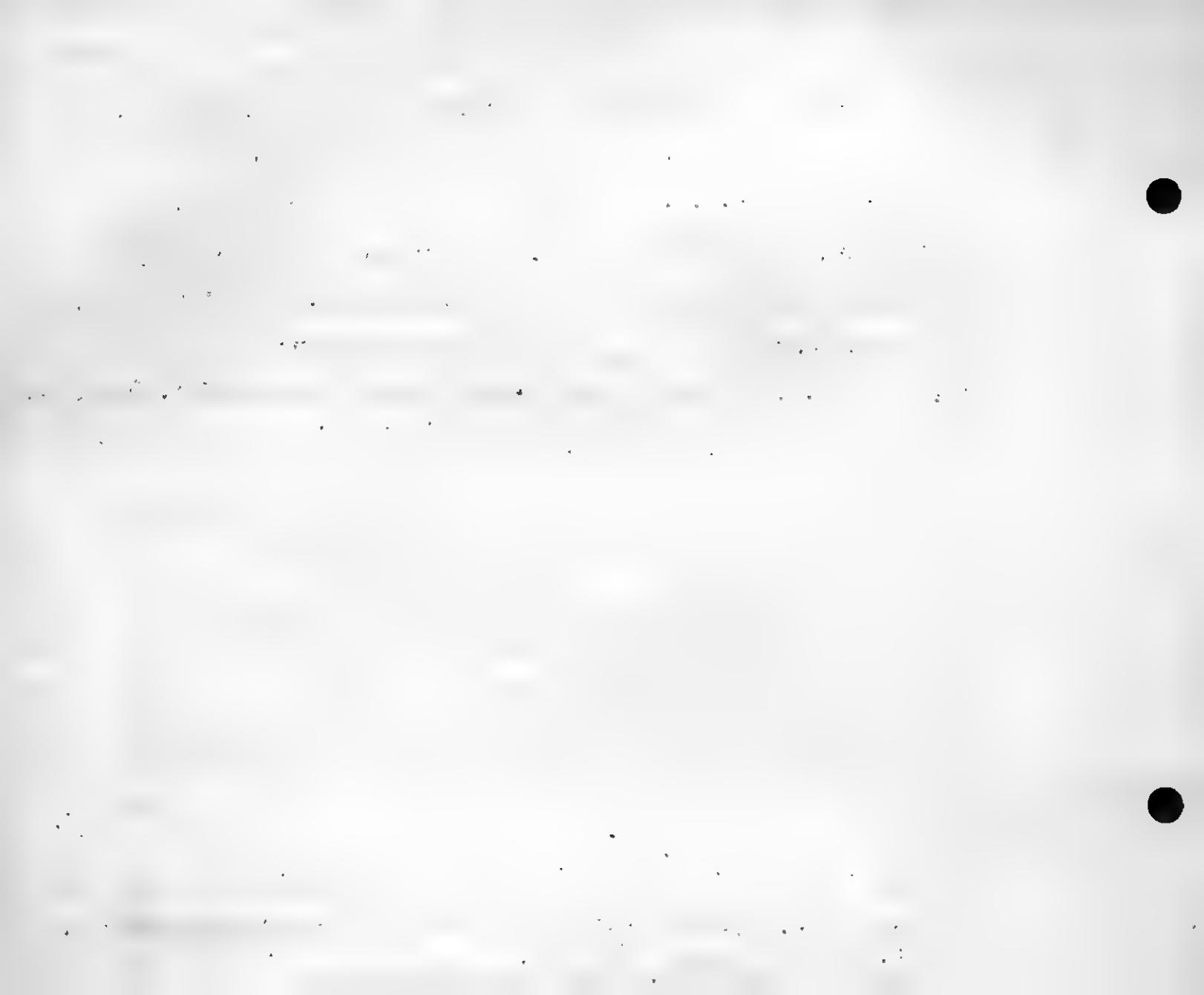
CERTIFICATE OF DEATH

032311

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

Page 4 may be retained by the hospital or attending physician.
11 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers, sign and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) John Joseph Matthews			2a. DATE OF DEATH Month February Day 8 Year 1968	2b. HOUR 10 AM
3. SEX Male		4. RACE White	5. DATE OF BIRTH Sept 29 1898	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Washington, Md.		10. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Base Ball Player		
11. CITY OR TOWN OF DEATH Hagerstown, Maryland		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Base Ball Player
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME Andrew Matthews		15. MOTHER'S MAIDEN NAME Elizabeth Owens		12b. STREET AND NUMBER 106 East Baltimore St
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO W.W. #1 213-30-3287		17. INFORMANT Address Miss Virginia Moats 106 E. Balto St
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4319		19. DUE TO, OR AS A CONSEQUENCE OF Cerebral Hemorrhage		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) DUE TO, OR AS A CONSEQUENCE OF		
(c)				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3318				
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21e. TIME OF INJURY HOUR A.M. 19 Month Feb Day 8 Year 1968	21f. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21g. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21i. LOCATION Street or R.F.D. No.	City or Town Hagerstown County Maryland State Md.
22a. I certify that (I) (this hospital) attended the deceased from 1 Feb , 1968, to 8 Feb , 1968, that (I) (we) last saw the deceased alive on 8 Feb , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Eldon Hoachler		22c. DEGREE ATTENDING PHYS.	22d. MED DIRECTOR <input checked="" type="checkbox"/>	22e. STAFF PHYS. <input type="checkbox"/>
22f. PHYSICIAN'S NAME (Type) Eldon Hoachler		22g. DATE SIGNED 2/9/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 12, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown, Maryland (County) Maryland (State)
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc.		25a. ADDRESS Hagerstown, Maryland.	25b. REGISTRAR'S SIGNATURE FEB 13 1968	



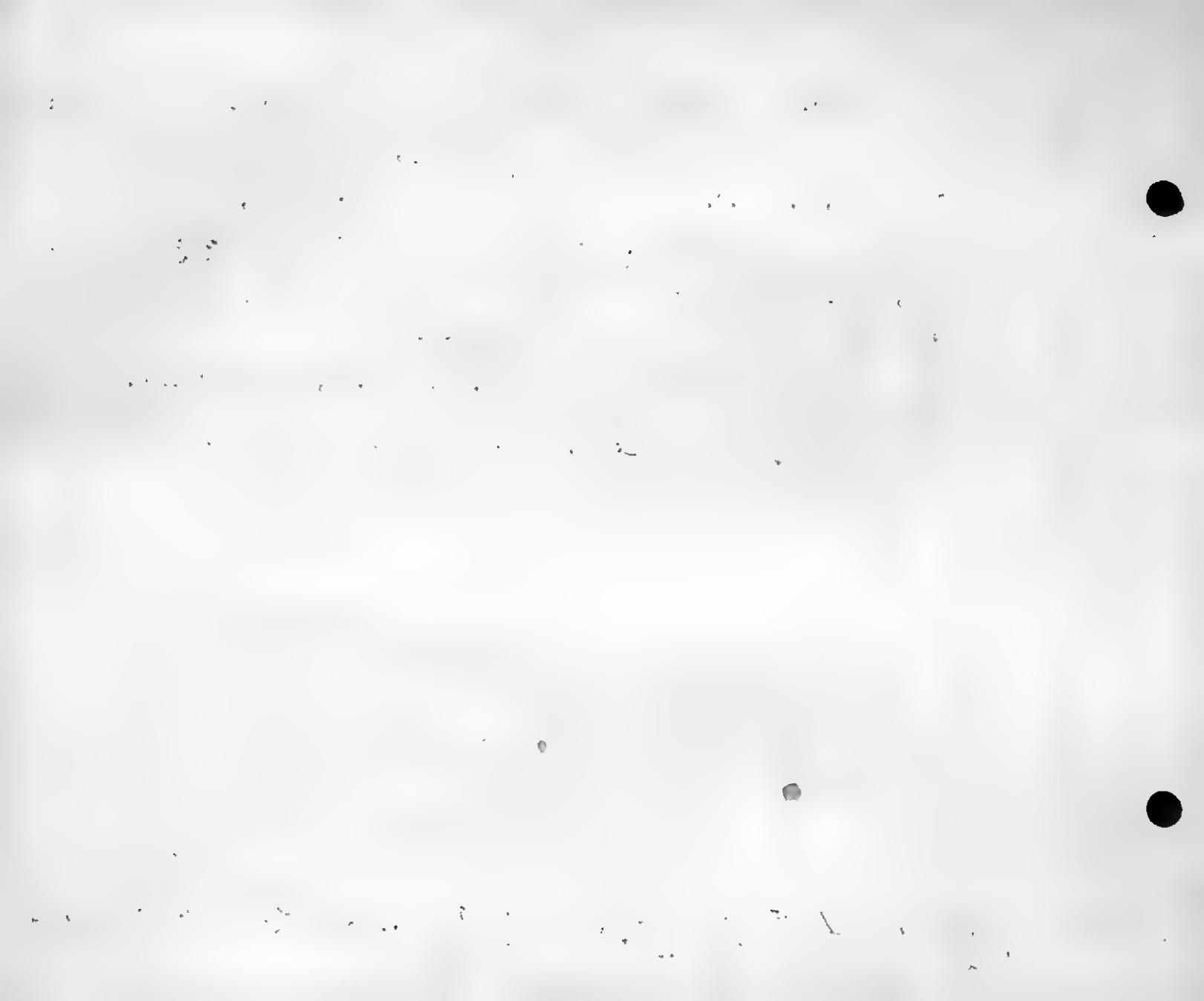
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First Rachel	Middle Jackson	Last McFadden	2a. DATE OF DEATH Month February	Day 6, 1968	2b. HOUR 4:25 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 15, 1886		6. AGE (In years last birthday) 81		IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS M.N. 0		
7a. BIRTHPLACE (State or foreign country) Davidport, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington,						
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital address) Williamsport Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY Not own Home						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Seaford, Delaware		13b. COUNTY Sussex		13c. CITY OR TOWN Seaford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 52 Nanticoke Annex				
14. FATHER'S NAME First Elihu Boyd		Middle Last		15. MOTHER'S MAIDEN NAME First Rachel Jackson		Middle		Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Mrs. John Cameron, Spencerville, Md.		Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (Gram Negative - with shock)		DUE TO, OR AS A CONSEQUENCE OF Chronic Pyelonephritis.										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause 5700		(b)										
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1968 , to Feb. 1, 1968 , that (I) (we) last saw the deceased alive on Feb. 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Charles R. Spencer		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR		STAFF PHYS.		22e. DATE SIGNED Feb 6, 1968				
22d. PHYSICIAN'S NAME (Type) Charles R. Spencer		22e. ADDRESS 145 S. Royal St.										
23a. BURIAL, CREMATION, REMDVAL (Specify) Burial		23b. DATE Feb 9, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Hopewell Cem.		23d. LOCATION (City or Town) Port Deposit		(County) Cecil Md.		(State)		
24. FUNERAL DIRECTOR John E. Mulligan		ADDRESS 811 McAllister St. S. Suite 100		25a. REC'D BY REGISTRAR Feb 9, 1968		25b. REGISTRAR'S SIGNATURE John E. Mulligan						
30M REV. 1/68												



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Mary	Middle Elizabeth	Lost McKenney	2a. DATE OF DEATH Month Feb	2b. HOUR Year 1968 12:55 P.M.					
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH Dec 7 1912		6. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	
7a. BIRTHPLACE (State or foreign country) Shepherdstown		7b. CITIZEN OF WHAT COUNTRY? W. Va. USA		8. MARRIED WIDOWED		9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Hagerstown Md		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.		12a. USUAL OCCUPATION (kind of work done during most of working life, even if retired) Domestic		12b. KIND OF BUSINESS OR INDUSTRY Private Fam					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) Maryland		13b. CITY OR TOWN Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY (check) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 400B Park Place				
14. FATHER'S NAME Isaac		15. MOTHER'S MAIDEN NAME Wilson		16. SOCIAL SECURITY NO. 215-26-8257		17. INFORMANT Garfield McKenny		Address 400B Park Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Hemorrhage</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 44 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cerebro-Vascular Disease</u> ? DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 44											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2 Dec 1968</u> to <u>3 Feb 1968</u> , that (I) (we) last saw the deceased alive on <u>3 Feb 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 3 Feb. 1968	
22d. PHYSICIAN'S NAME (Type) W. N. FENDER		22e. ADDRESS 218 N. Potowmack St., Hagerstown, Md.									
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE Feb 6 1968		23c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown Md.		(County)			(State)
24. FUNERAL DIRECTOR John R. Watson Jr., Hagerstown Md.		ADDRESS		25a. REC'D BY REGISTRAR FEB 9 1968		25b. REGISTRAR'S SIGNATURE Charles J. Geiger					
VR A15 (4) 30M REV. 1/68											

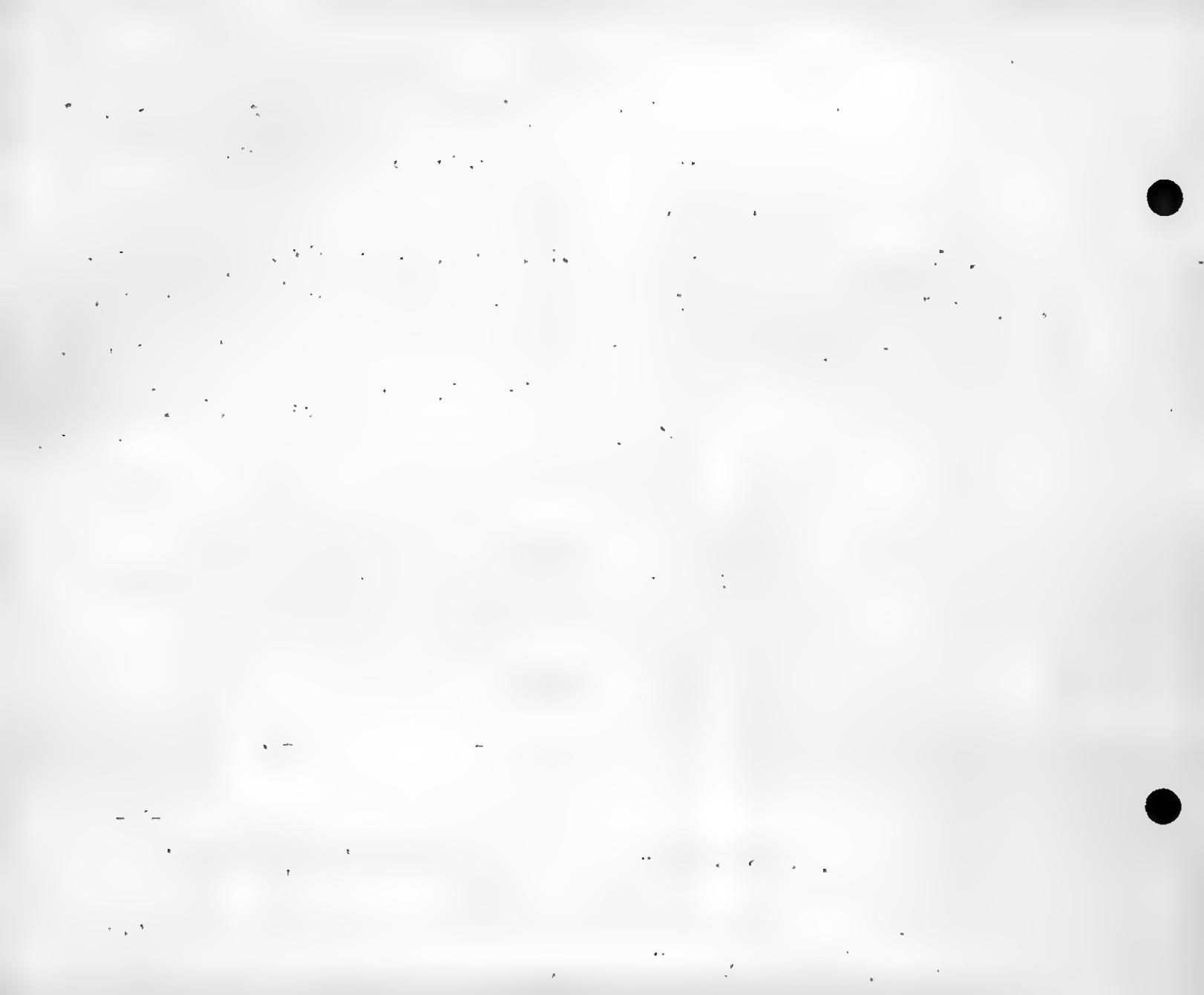


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED NAME (Type or print)	First MARY	Middle ELIZABETH	Lost	2a. DATE OF DEATH Month Feb	Day 17	Year 1968	2b. HOUR 8: PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 3, 1900	6. AGE (In years last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN 0			
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WOOOWEO <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Maryland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Cty. Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USE RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 319 Mitchell Ave.			
14. FATHER'S NAME First Samuel	Middle Eavey	15. MOTHER'S MAIDEN NAME First Middle Mowen	Mahala	Shives			
16a. WAS DECEASED EVER IN U.S. ARMEED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. none	17. INFORMANT Paul E. McNamee, 319 Mitchell Ave.	Address Hagerstown, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic coma 5/11/68 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 1/2/68 (b) anoxia of liver DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic heart disease complicated by diabetes				2 yrs			
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> If either, notify medical examiner	21b. TIME OF INJURY HOUR A.M. 19 P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.O. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 2-17-68 , to 2-17-68 , 19 68 , that (I) (we) last saw the deceased alive on 2-17-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Edson B. Moody</i>	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2-19-68					
22d. PHYSICIAN'S NAME (Type) Dr. Edson B. Moody	22e. ADDRESS 363 S. Cleveland Ave.	Hagerstown, Maryland 21740					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/20/68	23c. NAME OF CEMETERY OR CREMATORIAL Dunkard Cemetery	23d. LOCATION (City or Town) Broadfording Wash., Md.	(County)	(State)		
24. FUNERAL DIRECTOR Hagerstown, Md.	ADDRESS Andrew K. Coffman Funeral Home, Inc.	25a. REC'D BY REGISTRAR FEB 21 1968	25b. REGISTRAR'S SIGNATURE <i>James J. Coffman</i>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
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1 M	252	3 j3234						
2 DECEASED NAME (Type or print)	First ADA	Middle FLORENCE	Last MIDDLEKAUFF	20. DATE OF DEATH Month February	Day 4	Year 1968	2b. HOUR 30PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH April 3 1873	6. AGE (In years last birthday) 95 yrs.	F JNOER 1 YEAR MONTHS	F JNOER 24 HRS DAYS	HOURS	MIN	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1909 Virginia Ave	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Work	12b. KIND OF BUSINESS OR IND. STRY Own Home					
13a. US. RESIDENCE (Where deceased admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1909 Virginia Ave.				
14. FATHER'S NAME First Jacob Leatherman	Middle	Last	15. MOTHER'S MAIDEN NAME Mary E. Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. None	17. INFORMANT Margaret C. Middlekauff	Address 1909 Virginia Ave. Hagerstown Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pneumonia</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs				
481X Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 492X				DUE TO, OR AS A CONSEQUENCE OF (b) <i>Viral?</i>				
				DUE TO, OR AS A CONSEQUENCE OF (c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive heart failure</i>								
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. <input type="checkbox"/> P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) at work <input type="checkbox"/>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22a. I certify that (1) this hospital attended the deceased from <i>Jan 1959</i> to <i>Feb 8, 1968</i> , that (2) (we) last saw the deceased alive on <i>Feb 8, 1968</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>M.E. Byrkit MD</i>	22c. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	DATE SIGNED 2-7-68						
22d. PHYSICIAN'S NAME (Type) <i>M.E. Byrkit</i>	22e. ADDRESS <i>Williamsport Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3/8/68	23c. NAME OF CEMETERY OR CREMATORIUM <i>Bakersville Cemetery</i>	23d. LOCATION (City or Town) <i>Bakersville</i>	(County) <i>Maryland</i>	(State)			
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown Maryland	ADDRESS Andrew K. Coffman Funeral Home Inc. Hagerstown Maryland	25a. REC'D BY REGISTRAR DATE <i>Feb 9 1968</i>	25b. REGISTRAR'S SIGNATURE <i>new judge</i>					

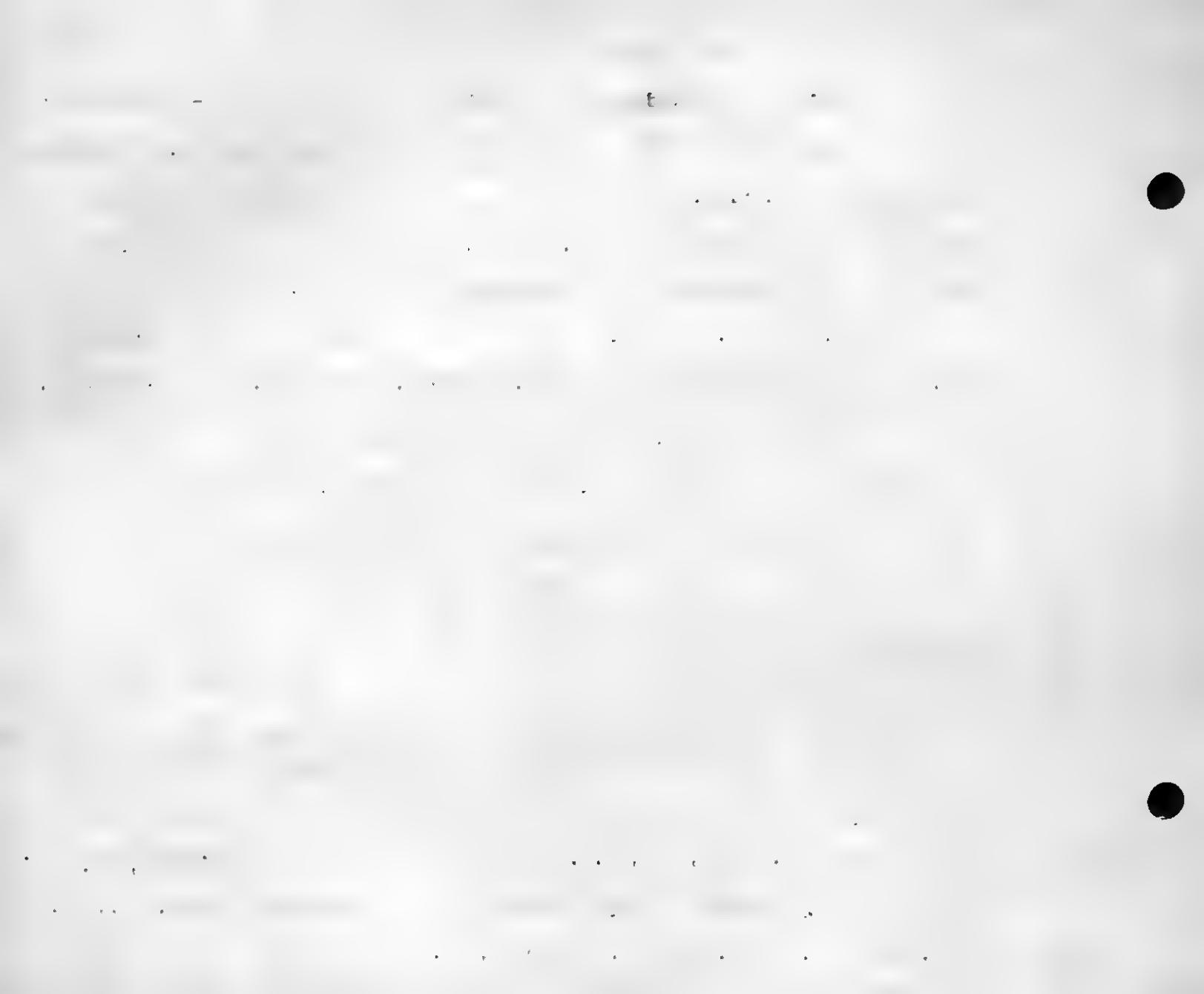


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First Mark	Middle Theodore	Last Moats	2a DATE KNOWN (Type or Print)	Month 2	Day 25	Year 1968	2b HOUR 8:30A	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7f UNDER 1 YEAR MONTHS 3	7f UNDER 24 HRS DAYS 11	7f UNDER 24 HRS HOURS 24	7f UNDER 24 HRS MIN 00	2c DATE PRONOUNCED DEAD Month February	Day 25	Year 1968	2d HOUR 8:30A
Male	White	March 1, 1964	3 yrs								
7b BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington			
Hagerstown		U. S. A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital 9 ye. street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) None			12b. KIND OF BUSINESS OR INDUSTRY None		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? Boonsboro		13e. STREET AND NUMBER Rfd. 1					
14. FATHER'S NAME Milton			First D.	Middle Moats	Last	15. MOTHER'S MAIDEN NAME Maxine			16. ADDRESS Boonsboro, Md.		
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.			16b. SOCIAL SECURITY NO (If yes give war or dates of service) None			17. INFORMANT Mr. Milton D. Moats, Rfd. 1, Boonsboro, Md.			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 min.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Reproductive gastric cancer</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause list. (b) <i>Ac. viral upper Respiratory Tract</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No. City or Town County State					
22o. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Edward W. Ditto, III, M.D.</i>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED <i>2/26/68</i>		
EXAMINER'S NAME (Type)									ADDRESS (Street, city, town, or county) 217 W. Washington St. Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-28-68		23c. NAME OF CEMETERY OR CREMATORIAL Manor Cemetery			23d. LOCATION (City or Town) Tilghmanton Wash. Co., Md.		(County) Tilghmanton Wash. Co., Md.		(State) Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.			ADDRESS			25a. REC'D BY REGISTRAR FEB 28 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		



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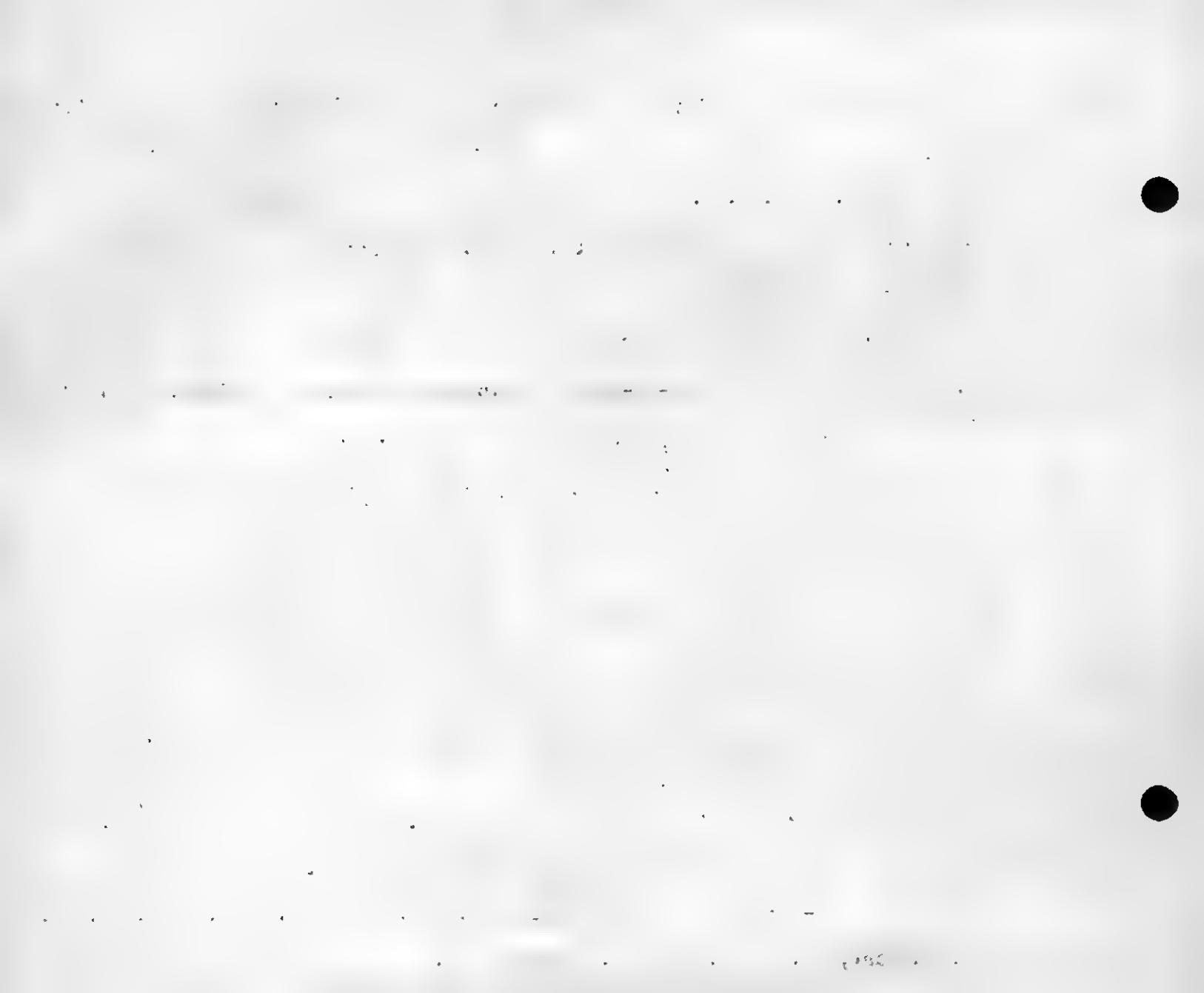
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

33236

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 2 hours after death.

1. DECEASED NAME (Type or print)	First Hays	Middle Stanley	Last Mullendore	2a. DATE OF DEATH Month February	Day 20	Year 1968	2b. HOUR 12:45 AM
3. SEX Male	4 RACE White	5 DATE OF BIRTH May 19, 1894		6 AGE (In years last birthday) 73		IF UNDER 1 YEAR 9 MONTHS	
7a. BIRTHPLACE (State or foreign country) Gapland, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		IF UNDER 24 HRS 1 MONTH 9 DAYS HOURS 1 MIN	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Gapland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER X	
14. FATHER'S NAME Enory	First Alvey	Middle Mullendore	Last	15. MOTHER'S MAIDEN NAME Minnie	Middle Wyand	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. 214-36-0651		17. INFORMANT Mrs. Bessie Mullendore, Gapland, Maryland	Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Hydrocephrosis</i> 591X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Haemorrhage of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs 4 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <i>Feb 17, 1968</i> , to <i>Feb 20, 1968</i> , that (I) (we) last saw the deceased alive on <i>Feb. 17, 1968</i> , and that in <i>(we)</i> (our) opinion death occurred on the date and hour and from the causes stated above, <i>(we)</i> (did) <i>(did not)</i> view the body after death.							
22b. SIGNATURE <i>G. W. Elavan</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>Feb 27, 1968</i>		
22d. PHYSICIAN'S NAME (Type) <i>G. W. Elavan</i>		22e. ADDRESS <i>Boonsboro, Md.</i>					
23a. BURIAL, CREMATION, Burial (Specify)		23b. DATE 2-23-68	23c. NAME OF CEMETERY OR CREMATORIAL Brownsville Hgts. Cem.		23d. LOCATION (City or Town) Brownsville, Wash. Co. Md.	(County)	(State)
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				ADDRESS	25a. REC'D BY REGISTRAR FEB 26 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First DANIEL	Middle JOSEPH	Last MULLIGAN	2a. DATE OF DEATH Month 2	Day 5	Year 68	2b. HOUR 12:20			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DECEMBER 1, 1904		6. AGE (In years last birthday) 63 YRS.		F. UNDER 1 YEAR MONTHS 0	F. UNDER 24 HRS. DAYS 0	F. HOURS 0	F. MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND ALLEGANY CO.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		Md.			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) PAINTER		12b. KIND OF BUSINESS OR INDUSTRY CONTRACTOR					
13a. USUAL RESIDENCE (Where deceased admission) STATE MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 908 LANVALE STREET			
14. FATHER'S NAME DANIEL		First F.	Middle MULLIGAN, SR.	Last	15. MOTHER'S MAIDEN NAME MARY			Middle BARGER	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. *****		17. INFORMANT 214-09-1314		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sev. Wks.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 486X		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic alcoholism, cirrhoses of liver											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med'cal examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 2/2/68 , 19, to 2/5/68 , 19, that (I) (we) last saw the deceased alive on 2/5/68 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (you) (they) (did not) view the body after death.											
22b. SIGNATURE <i>Howard N. Weeks</i>		22c. DEGREE MD.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		DATE SIGNED 2/5/68	
22d. PHYSICIAN'S NAME (Type) HOWARD N. WEEKS, MD.		22e. ADDRESS 580 NORTHERN AVENUE, HAGERSTOWN, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/7/68		23c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEMETERY		23d. LOCATION (City or Town) HAGERSTOWN		(County) WASH. CO.		(State) MD.	
24. FUNERAL DIRECTOR <i>Charles J. Weeks</i>		ADDRESS HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE FEB 6 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. Weeks</i>					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)			First Ethel	Middle Ada	Last Newey	20. DATE OF DEATH Month 2	Day 10	Year 1968	26. HOUR 5:45	
3. SEX female		4. RACE white	5. DATE OF BIRTH 9-2-1884			6. AGE (In years last birthday) 83		IF UNDER 1 YEAR MONTHS 83	IF UNDER 24 HRS DAYS 0	
7a. BIRTHPLACE (State or foreign country) England		7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington			12b. KIND OF BUSINESS OR INDUSTRY	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life ever pursued) housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2007 Greenfield Rd			
14. FATHER'S NAME First William V. Collier		Middle 	Last 	15. MOTHER'S MAIDEN NAME First Alice Johnson			Middle 	Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. none			17. INFORMANT Mrs. Dorothy Zinkand, Hagerstown, Md.			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Malnutrition + Inanition										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause small bowel obstruction										18 mos.
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause recurrent carcinoma of (R) colon										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 2/12/68 to 2/10/68 , that (I) (we) last saw the deceased alive on 2/9/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Thomas V. Craig		DEGREE 	ATTENDING PHYS. 	MED. DIRECTOR 	STAFF PHYS. 	22c. DATE SIGNED 2/12/68				
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 247 N. Potomac, Hagerstown, Md.								
23a. BURIAL CREMATION, REMOVAL <input type="checkbox"/> Specify cremation		23b. DATE 2-13-68	23c. NAME OF CEMETERY OR CREMATORIAL Riverview Cemetery			23d. LOCATION (City or Town) Williamsport, Md.		(County)		(State)
24. FUNERAL DIRECTOR Hinchich Funeral Home, Hagerstown, Md.		ADDRESS 	25a. REC'D BY REGISTRAR DATE FEB 14 1968			25b. REGISTRAR'S SIGNATURE 				



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1 Film G398 2/28/68 kk

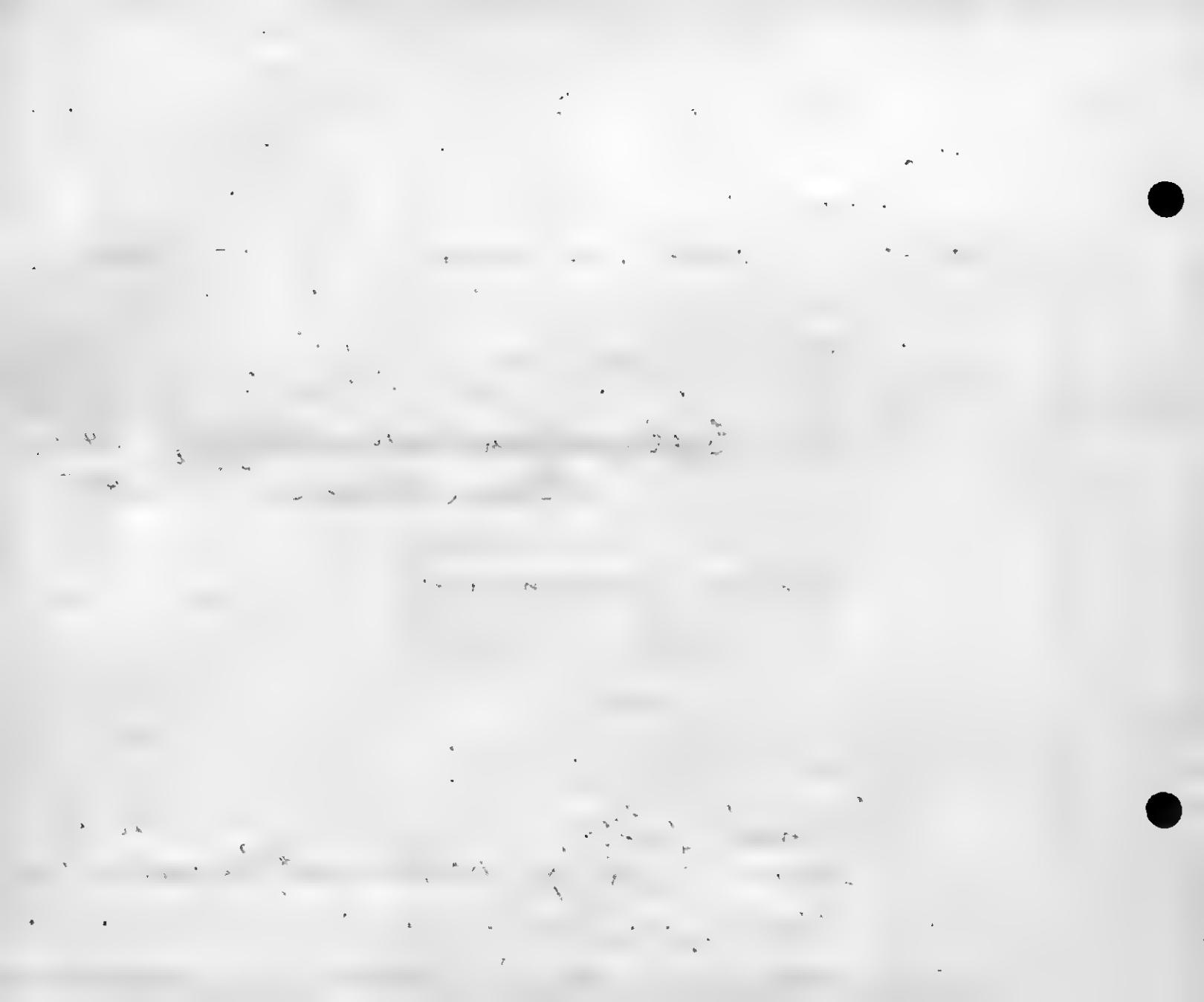
CERTIFICATE OF DEATH

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 DECEASED NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	2b. HOUR 8:50
George Edward Quinn, Jr.		February 25 Day 68 Year		2b. HOUR 8:50	
3. SEX Male	4 RACE White	5 DATE OF BIRTH 5/5/28	6 AGE (In years last birthday) 39	7 IF JUNIOR 1 YEAR MONTHS	8 IF JUNIOR 24 HRS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON	12b. KIND OF BUSINESS OR INDUSTRY EXPEDITOR - Mechanical Contractors	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working, for even if retired)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 8212 Queen Anne's Drive	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE E. Quinn Sr.		PAULINE		LENNON	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 677-36-7955	17 INFORMANT Mrs. George Quinn Jr. Silver Spring, Md.	Address 8212 Queen Anne's Bt.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sophagomalaciac ruptured to pleural cavity</i> APPROX. RATE INTERVAL 24 hrs 1351 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <i>Bran tumor</i> DUE TO, OR AS A CONSEQUENCE OF last (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Absular pneumonia</i>					
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from 2/12/68 to 2/26/68, that (I) (we) last saw the deceased alive on 2/25/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Edwin G. Riley</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED 2-26-68	
22d. PHYSICIAN'S NAME (Type) Edwin G. Riley		22e. ADDRESS 1500 Penna St, Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery	23d. LOCATION (City or Town) Prince Georges Co. Md.	(County) (State)
24. FUNERAL DIRECTOR S.H. Hines Co. Wash. D.C.		ADDRESS	25a. REC'D BY REGISTRAR FEB 27 1968	25b. REGISTRAR'S SIGNATURE Charles J. Jones	
VR A15 (4) 30M REV. 1/68					



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

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1. DECEASED NAME (Type or print)	First William	Middle Raymond	Last Rank	2a. DATE OF DEATH 2 Month 15 Day 68 Year	2b. HOUR 3:30P
3. SEX Male	4 RACE White	5. DATE OF BIRTH 12/1/95		6. AGE (In years last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. COUNTY OF DEATH WASHINGTON	
10. CITY OR TOWN OF DEATH HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Truck driver	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Allegany	13c. CITY OR TOWN Cumberland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Willowbrook Road	
14. FATHER'S NAME John	First Middle Rank	15. MOTHER'S MAIDEN NAME HENRIETTA		Middle	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 219-03-8358	17. INFORMANT MRS ANNA STRAW 1005 HARDING AVE CUMBERLAND	Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullous Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) or his hospital attended the deceased from <u>August 19, 1967</u> to <u>Feb. 15, 1968</u> , that (I) or we last saw the deceased alive on <u>Feb. 15, 1968</u> , and that in (my) or we opinion death occurred on the date and hour and from the causes stated above, (I) or we (did) or we view the body after death.					
22b. SIGNATURE <u>Domingo A. Garcia</u>					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Western Md. State Hospital, Hagerstown	22c. DATE SIGNED 2/16/68		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 19 FEB 68	23c. NAME OF CEMETERY OR CREMATORIUM ST LUKES CEMETERY	23d. LOCATION (City or Town) CUMBERLAND	(County) ALLEGANY MD.	(State)
24. FUNERAL DIRECTOR H. LEE SILCOX 404 DECATUR STREET CUMBERLAND			25a. RECD BY REGISTRAR FEB 19 1968	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



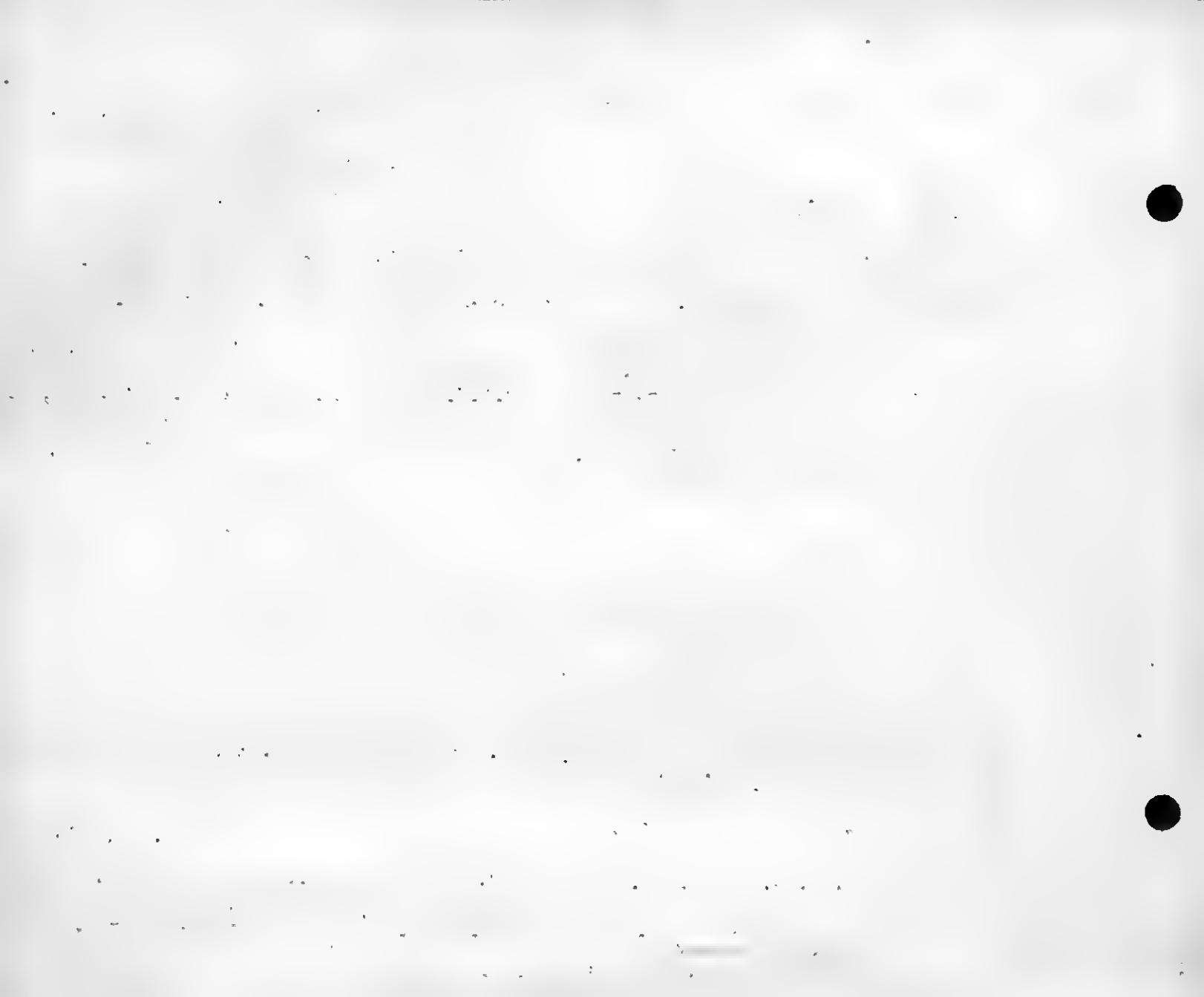
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

00259

03241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First Thomas	Middle Brackett	Last Reed	2a. DATE OF DEATH Month February	Day 20	Year 1968	2b. HOUR 4:31 M			
3. SEX		4. RACE		5. DATE OF BIRTH	6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS M.N.		
Male		White		January 24, 1899	69	YRS.					
7a. BIRTHPLACE (State or foreign country) Catoctin Furnace, Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Sheet Metal Foreman			12b. KIND OF BUSINESS OR INDUSTRY Refrig. Doors				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Maryland		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 409 N. Mulberry St.						
14. FATHER'S NAME First Samuel		Middle Howard	Last Reed	15. MOTHER'S MAIDEN NAME First Julia			Middle Florence	Last Janison	Address Mrs. J.B. Reed 409 N. Mulberry St. Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Ruptured Aortic Aneurysm											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from Feb. 15, 1968 , to Feb. 20, 1968 , that (I) (we) last saw the deceased alive on Feb. 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A. E. W. Ditte, Jr.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/>	MED DIRECTOR	<input type="checkbox"/>	STAFF PHYS.	<input type="checkbox"/>	22c. DATE SIGNED Feb. 21, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditte, Jr.		22e. ADDRESS 215 W. Washington St., Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/23/68		23c. NAME OF CEMETERY OR CREMATORIAL Cemetery Mt. Prospect Meth. Episc.			23d. LOCATION (City or Town) Lewisburg-Frederick-Md.			(County) 	(State)
24. FUNERAL DIRECTOR Wm. C. Hart		ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR FEB 26 1968			25b. REGISTRAR'S SIGNATURE <i>Charles J. Jones</i>				

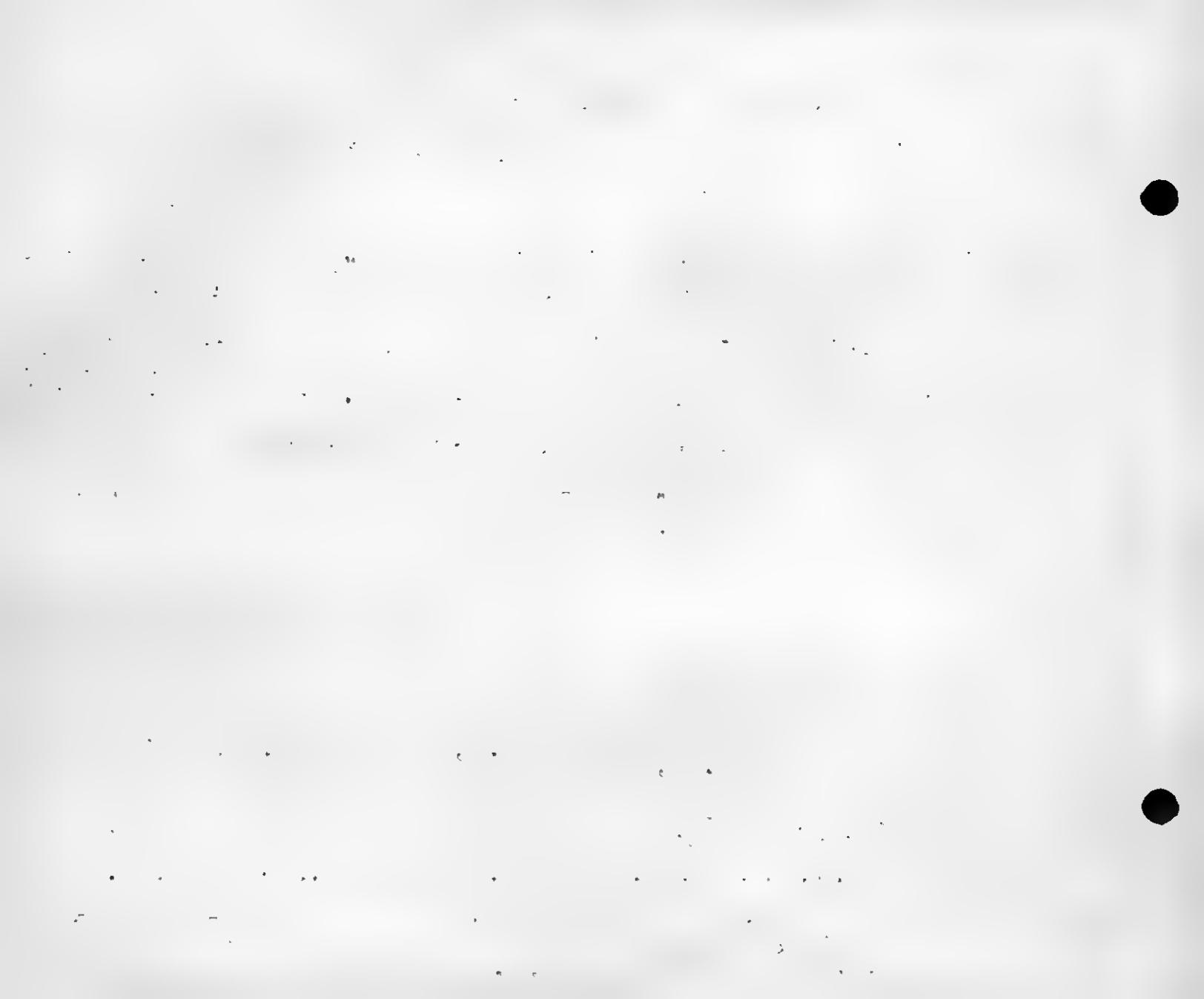


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>Bessie</i>	Middle <i>Eudora</i>	Lost <i>Reeder</i>	2a. DATE OF DEATH Month <i>2</i>		Day <i>27</i>	Year <i>68</i>	2b. HOUR <i>4:30 A.M.</i>						
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH <i>2-15-1878</i>		6. AGE (In years lost birthday) <i>90 yrs.</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Washington</i>		10. CITY OR TOWN OF DEATH <i>Williamsport</i>							
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hopewell Church Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <i>Md.</i>		13b. CITY OR TOWN <i>Wash</i>							
14. FATHER'S NAME First <i>Charles</i>		Middle <i>A.</i>	Lost <i>Ende</i>	15. MOTHER'S MAIDEN NAME First <i>Emma</i>		Middle <i>Tracey</i>	Lost <i>Ende</i>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>214-09-70720</i>		17. INFORMANT <i>Mark G. Wagner, supt. Wm. St. Md.</i>		Address <i>2750 Va Ave</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio Vascular Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Poly Arthritis</i>		Several years		DUE TO, OR AS A CONSEQUENCE OF (c) <i>Senility</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct. 1, 1962</u> , to <u>Feb. 29, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>A. E. W. Ditto</i>		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR		22e. STAFF PHYS.		22f. DATE SIGNED <i>2/29/68</i>							
22d. PHYSICIAN'S NAME (Type) <i>Dr. E. W. Ditto, Jr.</i>		22e. ADDRESS <i>215 W. Washington St., Hagerstown, Md.</i>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>3/2/68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Rose Hill Cemetery</i>		23d. LOCATION (City or Town) <i>Hagerstown-Washington-Md</i>		(County) <i>Hagerstown</i>		(State) <i>Washington-Md</i>					
24. FUNERAL DIRECTOR <i>Wm. C. Norsk</i>		ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>		25a. REC'D BY REGISTRAR <i>MM</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. Jagger</i>		MAR 4 1968							

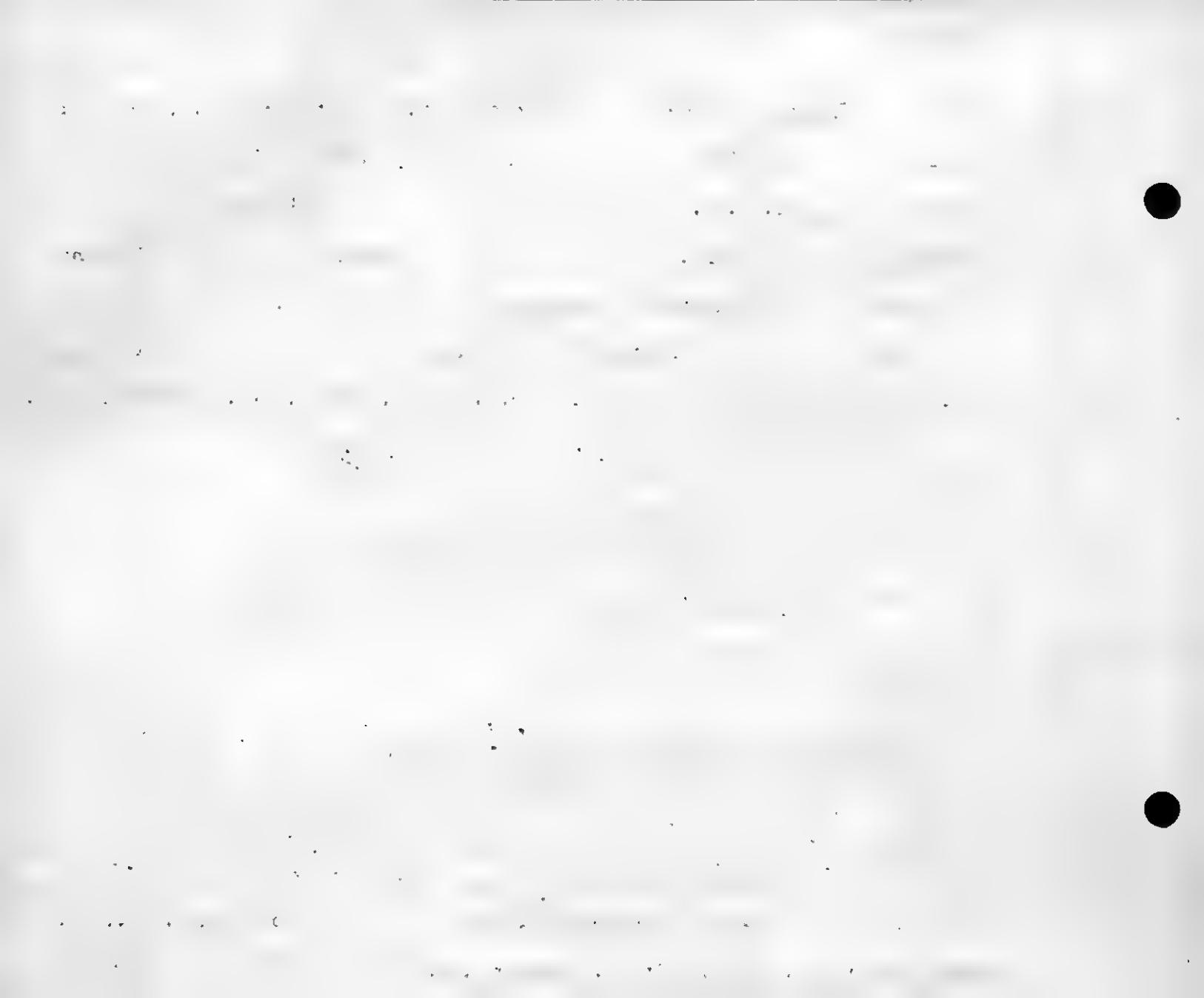


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15261
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH
16243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1-2 and 3-4. The certificate should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Lester	Middle James	Last Reeder, Sr.	2a. DATE OF DEATH Month February	2b. HOUR Year 1968			
3. SEX Male	4. RACE White	5. DATE OF BIRTH August 28, 1894		6. AGE (In years last birthday) 73	7. IF UNDER 1 YEAR MONTHS 5	8. IF UNDER 24 HRS. DAYS 21		
7b. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington	Md			
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rfd. 2		12a. US/JAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. 13b. CITY OR TOWN Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CTY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rfd. 2					
14. FATHER'S NAME First James	Middle Reeder	Last Betty	15. MOTHER'S MAIDEN NAME First Cronise					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. 219-36-4302	17. INFORMANT Mr. Mervil J. Reeder, Rfd. 2 Boonsboro, Md.	Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Canceroma of oesophagus</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mos		
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
22a. I certify that (I) (this hospital) attended the deceased from Feb 1, 1968 , to Feb 19, 1968 , that (I) (we) last saw the deceased alive on Feb 1, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>G.W. Levan</i>		DEGREE ATTENDING PHYS.	22c. DATE SIGNED 2-10-68	MED-DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (Type) G.W. Levan		22e. ADDRESS Boonsboro, Md.						
23a. BURIAL, CREMATION. REMOVAL (Specify) Burial		23b. DATE 2-22-68	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCATION (City or Town) Boonsboro Wash. Co., Md.	(County) Boonsboro	(State) Wash. Co., Md.		
24. FUNERAL DIRECTOR John H. Bast, Jr.		ADDRESS 112 N. Main St. Boonsboro, Md.		25a. RECD BY REGISTRAR FEB 26 1968	25b. REGISTRAR'S SIGNATURE <i>John H. Bast, Jr.</i>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMG Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First DAVID	Middle LESTER	Last RHINES	2a DATE KNOWN OF ESTI. DEATH MATED <input checked="" type="checkbox"/> Feb. 26, 1968	Month Feb.	Day 26	Year 1968	2b HOUR 8:30 A.M.
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 9/1/1893	6 AGE (In years last birthday) 74	7 IF UNDER 1 YEAR MONTHS YRS	8 IF UNDER 24 HRS HRS MIN	2c DATE PRONOUNCED DEAD Month Feb.				2d HOUR 10:10 A.M.
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON				
10 CITY OR TOWN OF DEATH HAGERSTOWN		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 8 EAST WASHINGTON ST.		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED PAINTER		12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MARYLAND		13b CITY OR TOWN WASHINGTON		13d INSIDE CITY J.M.157 HAGERSTOWN		13e STREET AND NUMBER 8 EAST WASHINGTON STREET,				
14 FATHER'S NAME JOHN		15 MOTHER'S MAIDEN NAME RHINES		16 MARY		17 UNKNOWN				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16b SOCIAL SECURITY NO If yes give name or dates of service *****		17 INFORMANT MRS. CATHERINE RHINES, HAGERSTOWN, MARYLAND.		18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: 4290		IMMEDIATE CAUSE (a) <u>Lobular Pneumonia, Lower Lobes, Bilateral</u> Several days DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <u>Cardiac Hypertrophy With Pulmonary Emphysema</u> Several years DUE TO, OR AS A CONSEQUENCE OF								
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION 1/27/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 1b)						
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EDWARD W. DITTO, JR. M.D.		EDWARD W. DITTO, JR. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED 2/27/68 215 W. WASHINGTON HAGERSTOWN, MD.		
23a BURIAL, CREMATION OR REMOVAL (Specify) BURIAL		23b DATE 2/28/68		23c NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEMETERY		23d LOCATION (City or Town) HAGERSTOWN, WASH. CO. MD.		(County) (State)		
24. FUNERAL DIRECTOR Walter L. Eschellinger		ADDRESS HAGERSTOWN, MARYLAND.		25a REC'D BY REGISTRAR MAR 4 1968		25b REGISTRAR'S SIGNATURE J. Charles Jones				



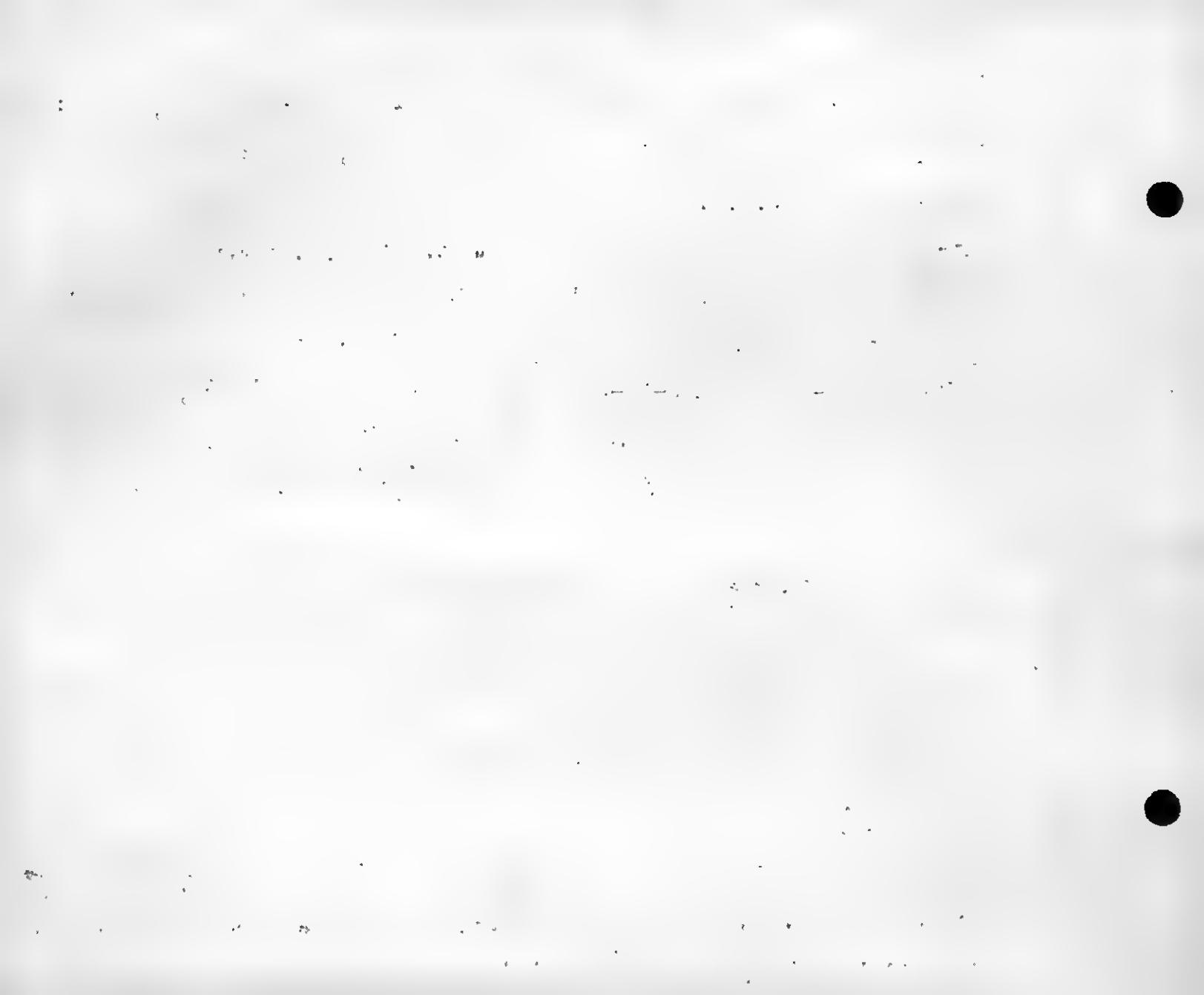
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)	First Fred	Middle Nicholas	Lost Rickard	2a. DATE OF DEATH Month February	Day 1, 1968	Year 1968	2b. HOUR P 3:45 M									
3. SEX Male	4 RACE White	5. DATE OF BIRTH February 13, 1885		6. AGE (in years lost birthday) 82 yrs.			IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN 0						
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington										
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) City Rattoiman		12b. KIND OF BUSINESS OR INDUSTRY Retired										
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMIT? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 323 S. Mulberry St.												
14. FATHER'S NAME First Francis Rickard	Middle —	Lost —	15. MOTHER'S M.A.DEN NAME First Mary G. Palmer	Middle —	Lost —											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 319-20-0451	17. INFORMANT Clyde Rickard	Address 323 S. Mulberry Street Hagerstown, Maryland		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.											
<p>IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4501</i></p> <p>(b) <i>Arteriosclerotic Heart Disease</i> <i>not known</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c)</p>																
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p><i>Pulmonary Embolism</i></p>																
19c. MEDICAL CERTIFICATION		19d. DATE OF OPERATION	19e. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year PM 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State													
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 24, 1968</i>, to <i>Feb. 1, 1968</i>, that (I) (we) last saw the deceased alive on <i>Feb. 1, 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>																
<p>22b. SIGNATURE <i>Arturo Riego</i></p>																
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS 119 E. Antietam, Hagerstown, Md.		22c. DATE SIGNED 2/2/68												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 3, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown	(County) Maryland	(State)										
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Maryland		ADDRESS Andrew K. Coffman Funeral Home Inc. Hagerstown, Maryland		25a. RECD BY REGISTRAR FEB 5 1968	25b. REGISTRAR'S SIGNATURE <i>Marie Yuge</i>											

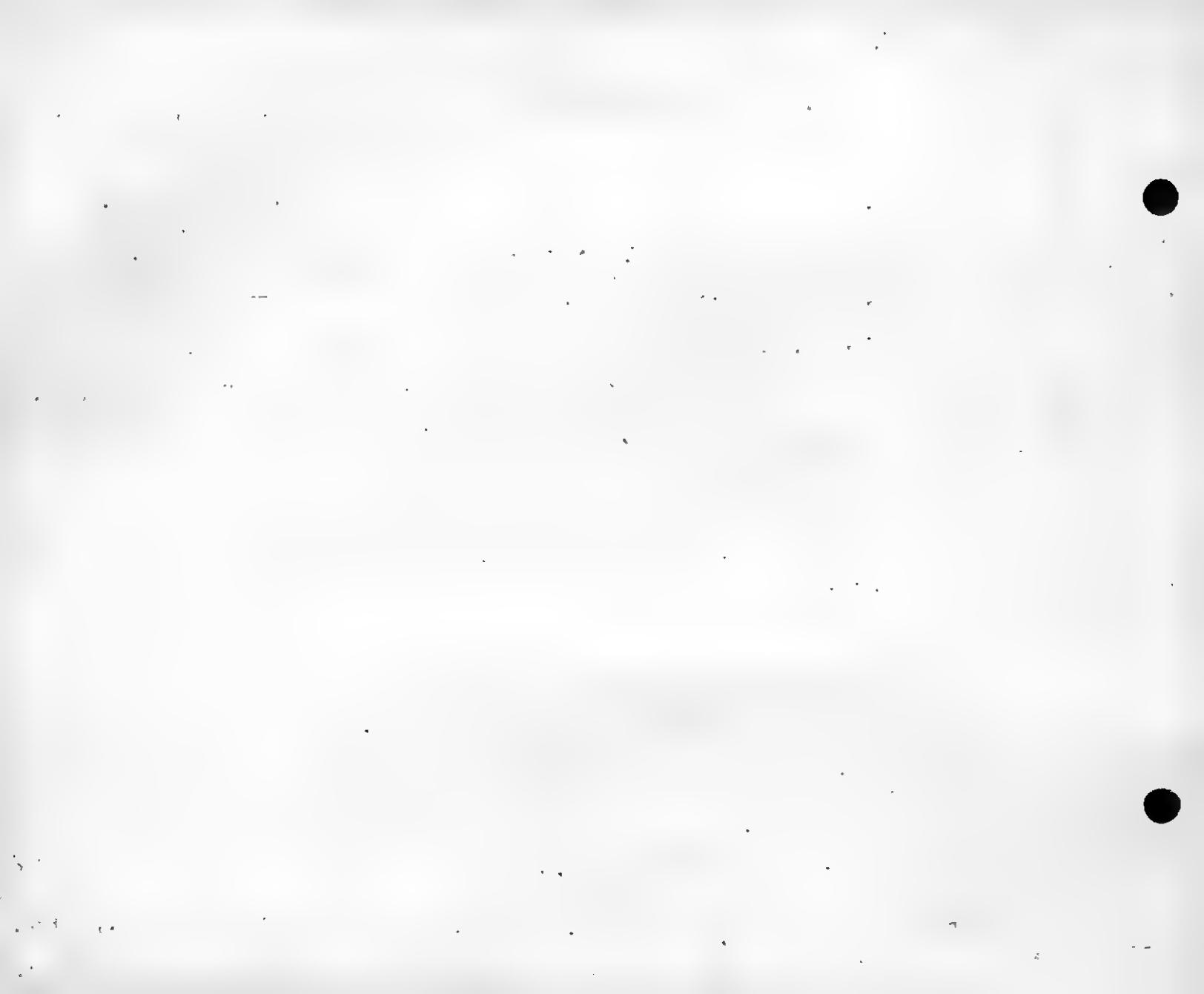


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be rejoined by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First J.	Middle HAYS	Lost	2a. DATE OF DEATH Month February 17, 1968	Day 1968	Year 5:45 A.M.	2b. HOUR 5:45 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 29 August 1911		6. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN.
7a. BIRTHPLACE (State or foreign country) Penns.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Washington County		Md.			
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 745 Guilford Avenue		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Dealer		12b. KIND OF BUSINESS OR INDUSTRY Auto					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Penns.		13b. COUNTY Huntingdon		13c. CITY OR TOWN Blairs Mills		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER --			
14. FATHER'S NAME John E. Robertson		15. MOTHER'S MAIDEN NAME Margaret Lauthers									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO 195-28-1077		17. INFORMANT Miss Dorothy Robertson		Address Blairs Mills, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		163		CANCERMA of Lung				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 163		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) In 1967 my trophy went. Present 6/1968											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 11-16-1967 to 2-17-1968, that (I) (we) last saw the deceased alive on 1-19-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John E. Robertson		22c. DEGREE ATTENDING PHYS.		22d. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22e. DATE SIGNED 2-17-68					
22d. PHYSICIAN'S NAME (Type) John E. Robertson		22e. ADDRESS 301 W. Preston Street, Hagerstown, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/20/1968		23c. NAME OF CEMETERY OR CREMATORIAL Upper Tuscarora Cemetery		23d. LOCATION (City or Town) Waterloo, Juniata Co., Penna.		(County) (State)			
24. FUNERAL DIRECTOR Harold M. Zimmerman		ADDRESS		25a. REC'D BY REGISTRAR FEB 20 1968		25b. REGISTRAR'S SIGNATURE James J. Jones					

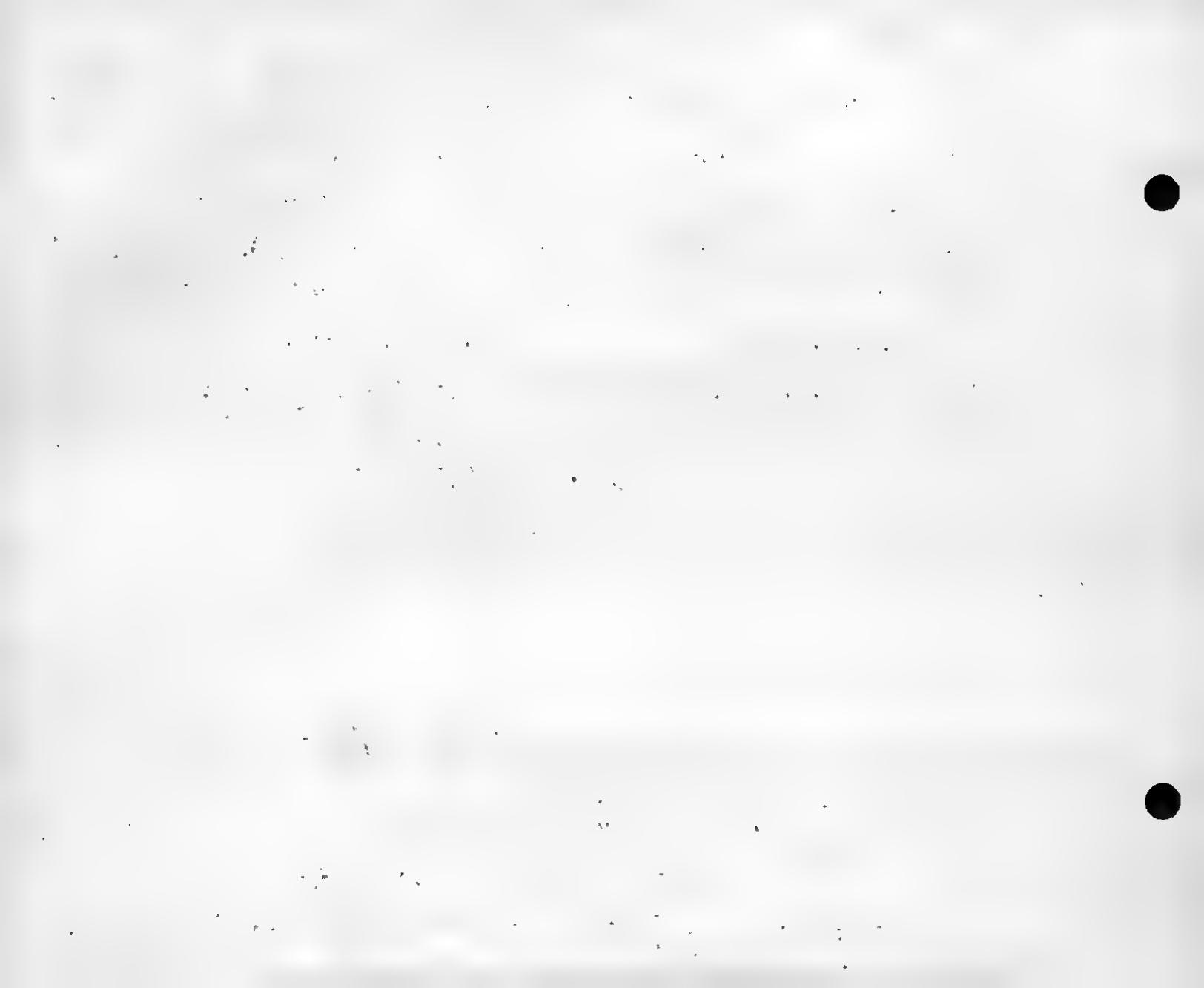


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR	
LESTER			WILLIAM	ROSS		Feb	15	1968	7 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
Male		White		March 19 1913		54 yrs.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Garrett Washington Co			
Maryland		USA									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Wash County Hospital				Painter's Helper		Victor			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		418 Fremont St			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last		
Charles W. Ross					Rose M. Layman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
Yes		W. W. 2 315-14-6386		Mrs Elva Baker		444 Carrollton Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY:		Hagerstown, Md.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 2839		Secondary anemia				1 mo.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF Malnutrition.				1 mo.					
(b)		DUE TO, OR AS A CONSEQUENCE OF Infection.				1 mo.					
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At Home, Farm, Street, Factory, Office Building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 16 1968</u> to <u>Feb 16 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 16 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
S. J. Beachley M.D.		Feb 17 1968									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
S. J. Beachley Hagerstown, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2/19/68		Rose Hill Cemetery		Hagerstown		Wash Co. Md.			
24. FUNERAL DIRECTOR		Hagerstown, Md. ADDRESS		25a. RECEIVED BY REGISTRAR		1968		REGISTRAR'S SIGNATURE			
Andrew K. Coffman Funeral Home Inc											
				DATE							

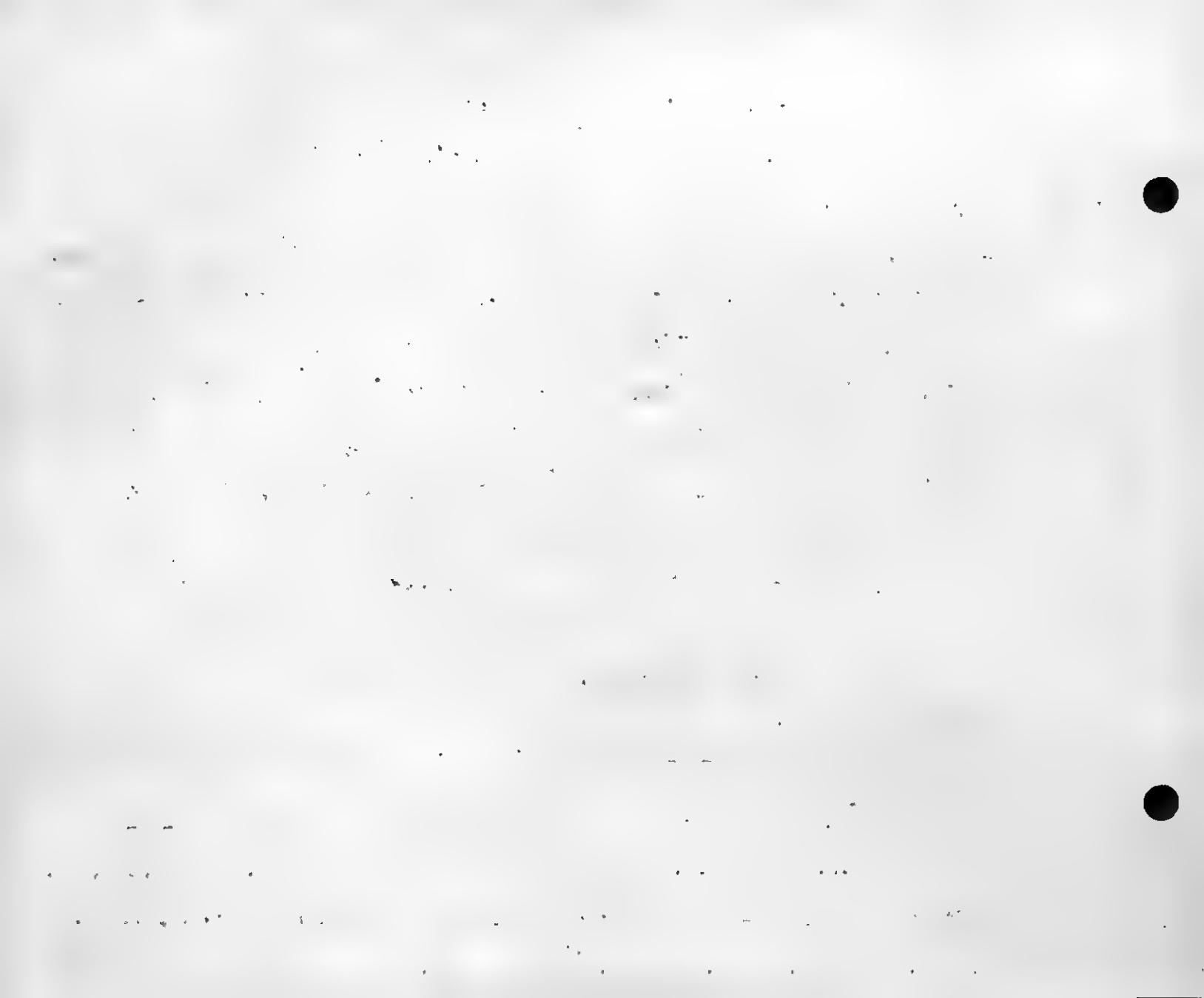


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. ■ Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First <i>SUSAN</i>	Middle <i>Veda</i>	Last <i>Rowe</i>	2a. DATE OF DEATH Month <i>December</i>	Day <i>21</i>	Year <i>1968</i>	2b. HOUR <i>8 A.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>October 6, 1882</i>		6. AGE (In years last birthday) <i>85</i> YRS		IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS DAYS <i>0</i>	IF UNDER 24 HRS HOURS <i>0</i>	IF UNDER 24 HRS MIN. <i>0</i>
7a. BIRTHPLACE (State or foreign country) <i>Boonsboro Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>					
10. CITY OR TOWN OF DEATH <i>Williamsport</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Williamsport Sanitarium</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>House Wife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Williamsport</i>		13d. INSIDE C.TY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <i>154 N. Artisan St.</i>			
14. FATHER'S NAME First <i>Benjamin R.</i>		Middle <i>Thumm</i>	Last <i></i>	15. MOTHER'S MAIDEN NAME First <i>Mary Ellen</i>		Middle <i>Drayton</i>	Last <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		16b. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Donna Peters</i>		Address <i>109 William Circle Williamsport, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral</i> <i>Atherosclerosis</i>		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <i>4551</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>marked cachexia + nephrosclerosis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <i></i>		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>10:00 A.M. May 20, 1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i></i>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.) <i></i>		21f. LOCATION Street or R.F.D. No. <i></i>		City or Town <i></i>		County <i></i>		State <i></i>	
22a. I certify that (I) (X) this hospital attended the deceased from <i>MAY 20, 1968</i> to <i>Feb 21, 1968</i> , that (I) (we) last saw the deceased alive on <i>2-11-68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>M.E. Byrkit M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>2-21-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>M.E. Byrkit M.D.</i>		22e. ADDRESS <i>28 West Potomac St. Williamsport, Md.</i>									
23a. BURIAL, CREMATION BURNING (Specify) <i>Burial</i>		23b. DATE <i>2-24-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Boonsboro Cemetery</i>		23d. LOCATION (City or Town) <i>Boonsboro Wash. Co., Md.</i>		(County) <i></i>		(State) <i></i>	
24. FUNERAL DIRECTOR <i>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</i>		ADDRESS		25a. RECD. BY REGISTRAR <i>FEB 28 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					



FOR STATE
HEALTH DEPT.

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

33264
Item 2a Film G395
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First JOHN	Middle BUNYAN	Last SHEETS	2a DATE KNOWN OF ESTI. DEATH MATED	Month 2 16	Day 1968	Year M	2b HOUR	
3 SEX MALE	4 RACE WHITE	5 DATE OF BIRTH 12/27/73	6 AGE (In years last birthday) 94	7f IF UNDER 1 YEAR MONTHS DAYS	8f IF UNDER 24 HRS MOJRS MIN.	2c DATE PRONOUNCED DEAD Month Feb. 16, 1968				2d. HOUR 7 P.M.	
7a BIRTHPLACE (State or foreign country) WEST VIRGINIA		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON				Md	
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL			12a US/JAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED OFFICIAL			12b KIND OF BUSINESS OR INDUSTRY MILLWORK		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON			13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e STREET AND NUMBER 57 SOUTH POTOMAC STREET,		
14. FATHER'S NAME SYLVESTER			15. MOTHER'S MAIDEN NAME SHEETS			16. CYNTHIA			17. RACER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. (If yes give year or dates of service) ****			17. INFORMANT MRS. MARK REED, 1104 POTOMAC AVE. MARYLAND.			ADDRESS HAGERSTOWN, MARYLAND.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fracture Of Left Femur And DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (last) (b) Arteriosclerotic Cardio Vascular Disease DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b) PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH A.M. P.M. Jan. 26, 1968		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) W. Washington Street			21f. LOCATION Street or R.F.D. No. City or Town County State			Fell while crossing street. Hagerstown, Washington, Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											22b. DATE SIGNED Feb. 17, 1968
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			APPROVED PARKERSBURG, WOOD CO. W. VA.		
23a BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b DATE 2/19/68		23c NAME OF CEMETERY OR CREMATORIAL I.O.O.F. CEMETERY			23d. LOCATION (City or Town) PARKERSBURG		(County) WOOD CO. W. VA.		
24. FUNERAL DIRECTOR Charles Renger		ADDRESS HAGERSTOWN, MARYLAND.			25a REC'D BY REGISTRAR FEB 20 1968		25b REGISTRAR'S SIGNATURE Charles J. Jenger				



3267
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

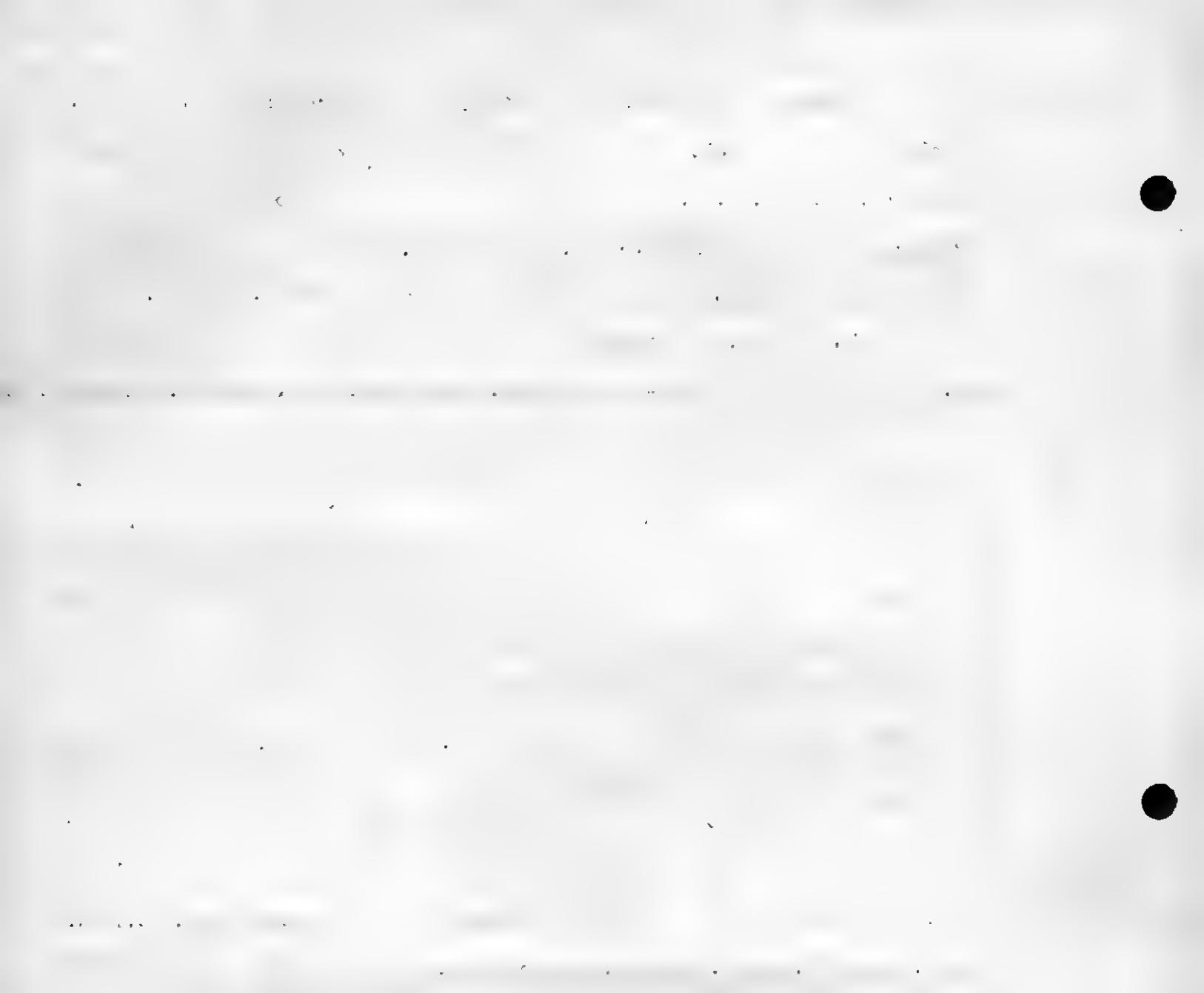
Item 3 Film G399 3/27/68 kk

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED NAME (Type or print)	First Mildred	Middle Eloise	Last Shepley	2a. DATE OF DEATH Month February	2b. HOUR Day 21	1968	5:30 P M
3. SEX Male	4 RACE White	5. DATE OF BIRTH October 27, 1912		6. AGE (In years last birthday) 55	IF UNDER 1 YEAR MONTHS 3	IF UNDER 24 HRS. DAYS 24	HOURS MIN 00
7a. BIRTHPLACE (State or foreign country) Boonsboro, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook			12b. KIND OF BUSINESS OR IND.STRY Tavern
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES	13e. STREET AND NUMBER 50 S. Main St.			
14. FATHER'S NAME First John	Middle K.	Last Cline	15. MOTHER'S MAIDEN NAME First Cora		Middle Smith	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-16-1289	17. INFORMANT Mrs. Cora Cline, 50 S. Main St. Boonsboro, Md.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute fulminant pneumonia APPROXIMATE INTERVAL Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last Acute adrenal insufficiency BETWEEN ONSET AND DEATH 3 Hours							
DUE TO, OR AS A CONSEQUENCE OF (b) acute adrenal insufficiency 3 Hours DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia 3 Weeks.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) +92x Hereditary tuberculosis of lungs							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING Cause of death (If either, notify medical examiner) at work	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 12-20 , 19 50 , to 2-21 , 19 58 , that (I) (we) last saw the deceased alive on 2-21 , 19 58 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. H. Cline, M.D.	DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 2.22-68			
22d. PHYSICIAN'S NAME (Type) J. H. Cline, M.D.	22e. ADDRESS Boonsboro, Md. 21713						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-25-68	23c. NAME OF CEMETERY OR CREMATORIAL Boonsboro Cemetery	23d. LOCATION (City or Town) Boonsboro Wash. Co., Md.	(County)	(State)		
24. FUNERAL DIRECTOR John H. Bast, Jr.	ADDRESS 112 N. Main St. Boonsboro, Md.	25a. REC'D BY REGISTRAR Charles J. Charles	25b. REGISTRAR'S SIGNATURE Charles J. Charles				
DATE FEB 28 1968							



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

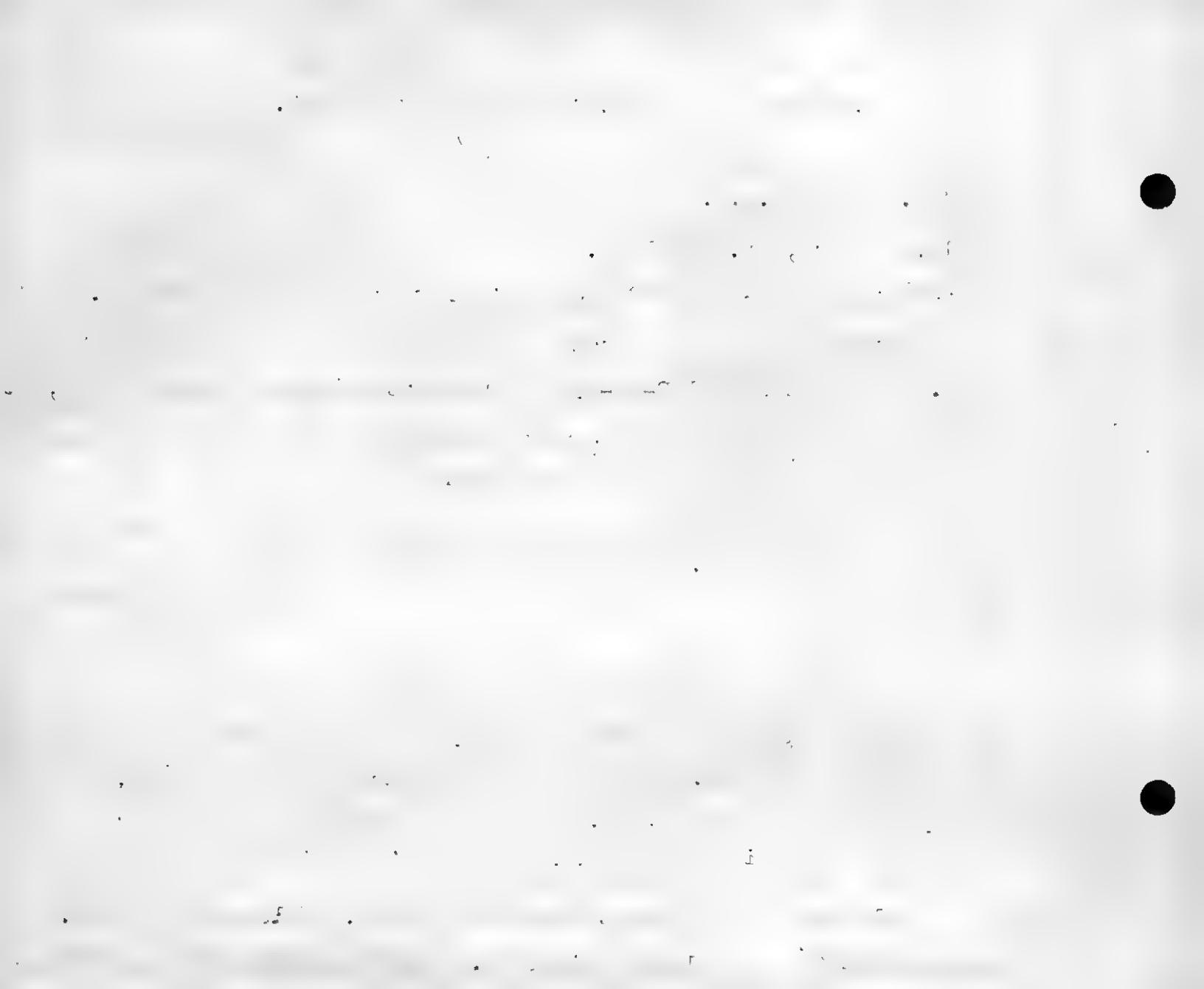
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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First Barbara	Middle Elizabeth	Last Shipp	2a. DATE OF DEATH Month Feb.	2b. HOUR Year 1968 8:30 P.M.	
3. SEX Female		4 RACE White	5. DATE OF BIRTH 10/9/82		6. AGE (In years last birthday) 85	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CIT.ZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		
10 CITY OR TOWN OF DEATH Clear Spring, Md.		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Mill St.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Home duties		12b. KIND OF BUSINESS OR INDUSTRY House work	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Washington	13c. CITY OR TOWN Clear Spring	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER #	None Mill St.	
14. FATHER'S NAME Henry		Middle Tosten	Last Elizabeth	15. MOTHER'S MAIDEN NAME Hoover	Address Mrs Dorothy Kayser Clear Spring, Md.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. None	17. INFORMANT 182-40-5542	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, Generalized</u>							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>180X</u>							
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of the Cervix</u>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
None							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or RFD No.	City or Town	County	State	
22a. I certify that (I) <u>Archie Robert Cohen</u> attended the deceased from <u>05/31/67, 19</u> to <u>02/26/68, 19</u> , that (I) <u>Archie Robert Cohen</u> last saw the deceased alive on <u>11/24/67, 19</u> and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (I) <u>Archie Robert Cohen</u> view the body after death. <u>did view the body after death.</u>							
22b. SIGNATURE <u>Archie Robert Cohen, M.D.</u>		DEGREE M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 02/27/68	
22d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22e. ADDRESS Clear Spring, Md. 21722					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/29/68	23c. NAME OF CEMETERY OR CREMATORIAL Welsh Run Brethren Cem.		23d. LOCATION (City or Town) Welsh Run	(County) Pa.	(State)
24. FUNERAL DIRECTOR Margaret Peulson		ADDRESS Clear Spring, Md.	25a. RECD BY REGISTRAR DATE MAR 1 1968		25b. REGISTRAR'S SIGNATURE Charles J. Judge		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

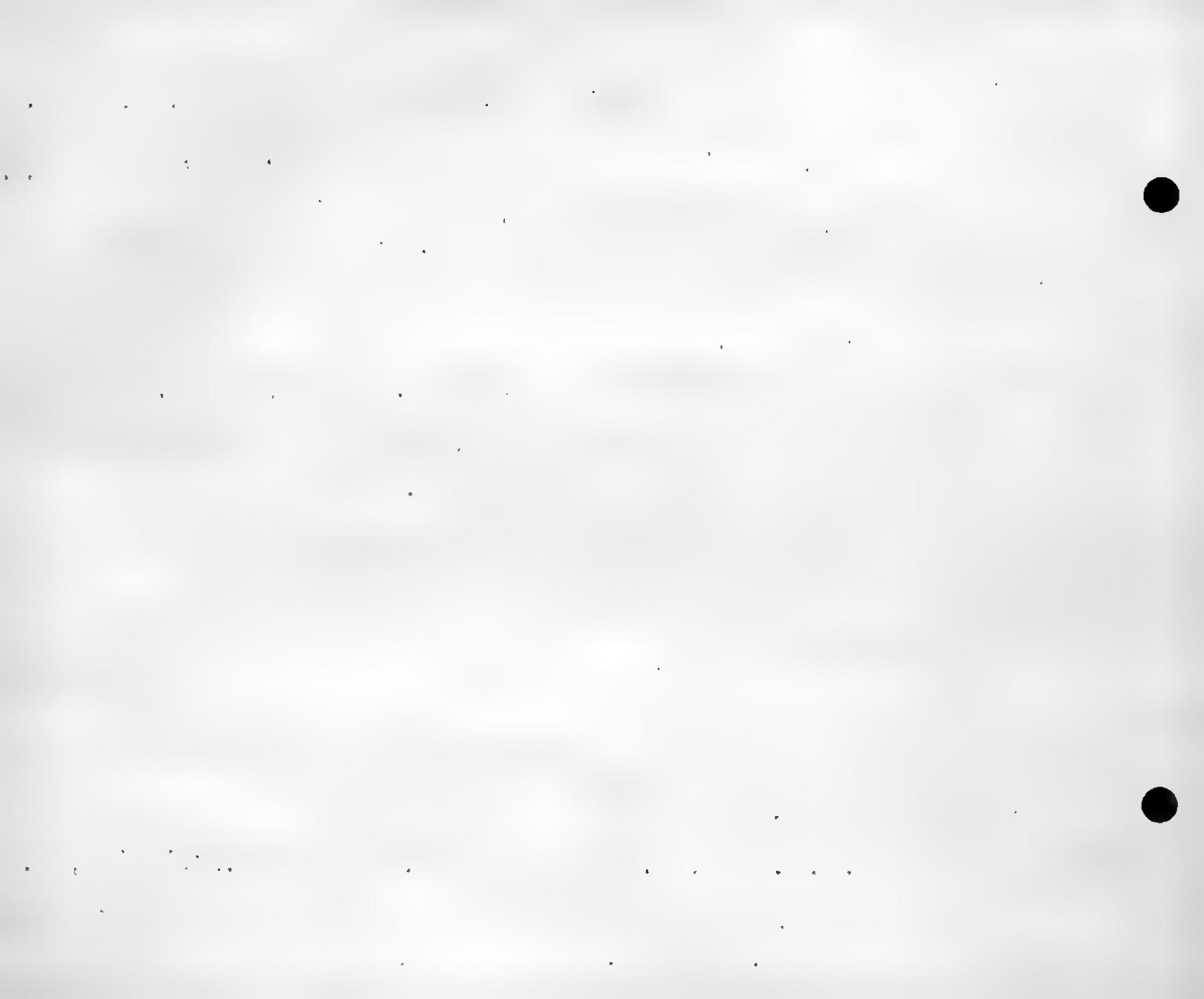
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'Pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PHM Base M. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b HOUR	
Carl			Elsworth Smith			Feb. 14, 1968				P. M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7f UNDER 1 YEAR MONTHS	7f UNDER 24 HRS DAYS	7h HOURS	2c DATE PRONOUNCED DEAD Month				2d HOUR
Male	White	Sept. 5 1911	56 yrs.	5	9		Feb. 16, 1968				P. M.
7g BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		Washington				Washington				Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Williamsport RFD 1			Falling Waters Rd. Rot'd Stone Mason			Williamsport			Washington Co		
13a USUAL RESIDENCE (Where deceased resided, if institution admission) STATE			13c CITY OR TOWN			13d INSIDE CITY OR TOWNSHIP			13e STREET AND NUMBER		
Maryland Washington			Williamsport			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RURAL- RFD #1		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Charles			A.	Smith		Gladys					Crumbaugh
16a WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO. (If yes give war or dates of service)			17 INFORMANT			ADDRESS		
No			213-12-7619			Mr. Edgar E. Smith			Fairplay Md. RFD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
Several years (b) <u>Exposure To Cold In Shack.</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <u>420</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20d AUTOPSY?					
19c MEDICAL CERTIFICATION			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f LOCATION Street or R.F.D. No			City or Town	County	State
21g INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			19								
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>E. W. Ditto</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			M.D. ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <u>Feb. 17, 1968</u>		
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			215 W. Washington St., Hagerstown, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b DATE <u>Feb. 17-68</u>			23c NAME OF CEMETERY OR CREMATORIAL <u>Manor Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Near Tilghmanton Wash. Md.</u>		
24 FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport Md.</u>			ADDRESS			25a REC'D BY REGISTRAR DATE <u>Feb 19 1968</u>			25b REGISTRAR'S SIGNATURE <u>Charles J. Ditto</u>		



1
13271
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

13253

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Neal	Middle Glenn	Last Smith	2a. DATE OF DEATH Feb. 21 Month Day 1968	2b. HOUR M
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 22, 1966		6. AGE (In years lost birthday) 1 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED WIDOWED	9. NEVER MARRIED DIVORCED	9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Smithsburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Kemp Horn Training Center		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Pa.	13b. COUNTY Montgomery	13c. CITY OR TOWN Brym Athyn	13d. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 2675 Alden Road	
14. FATHER'S NAME First Carey	Middle N. Smith	15. MOTHER'S MAIDEN NAME Lynn		Middle Last Mattner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	16b. SOCIAL SECURITY NO.	17. INFORMANT Carney N. Smith, 2675 Alden Road, Pa.		Address Brym Athyn,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. 7451 IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Brain Damage Syndrome</u> DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 Hrs.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>2-16-1968</u> to <u>2-21-1968</u> , that (I) (we) last saw the deceased alive on <u>2-21-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Charles F. Hess M.D.		DEGREE ATTENDING PHYS.	22c. DATE SIGNED 2-21-68		
22d. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.		22e. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 23, 1968	23c. NAME OF CEMETERY OR CREMATORIAL Brym Athyn Cemetery		23d. LOCATION (City or Town) Brym Athyn	(County) Montgomery (State) Pa.
24. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Md.	ADDRESS		25a. REC'D BY REGISTRAR FEB 26 1968	25b. REGISTRAR'S SIGNATURE friendly George	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

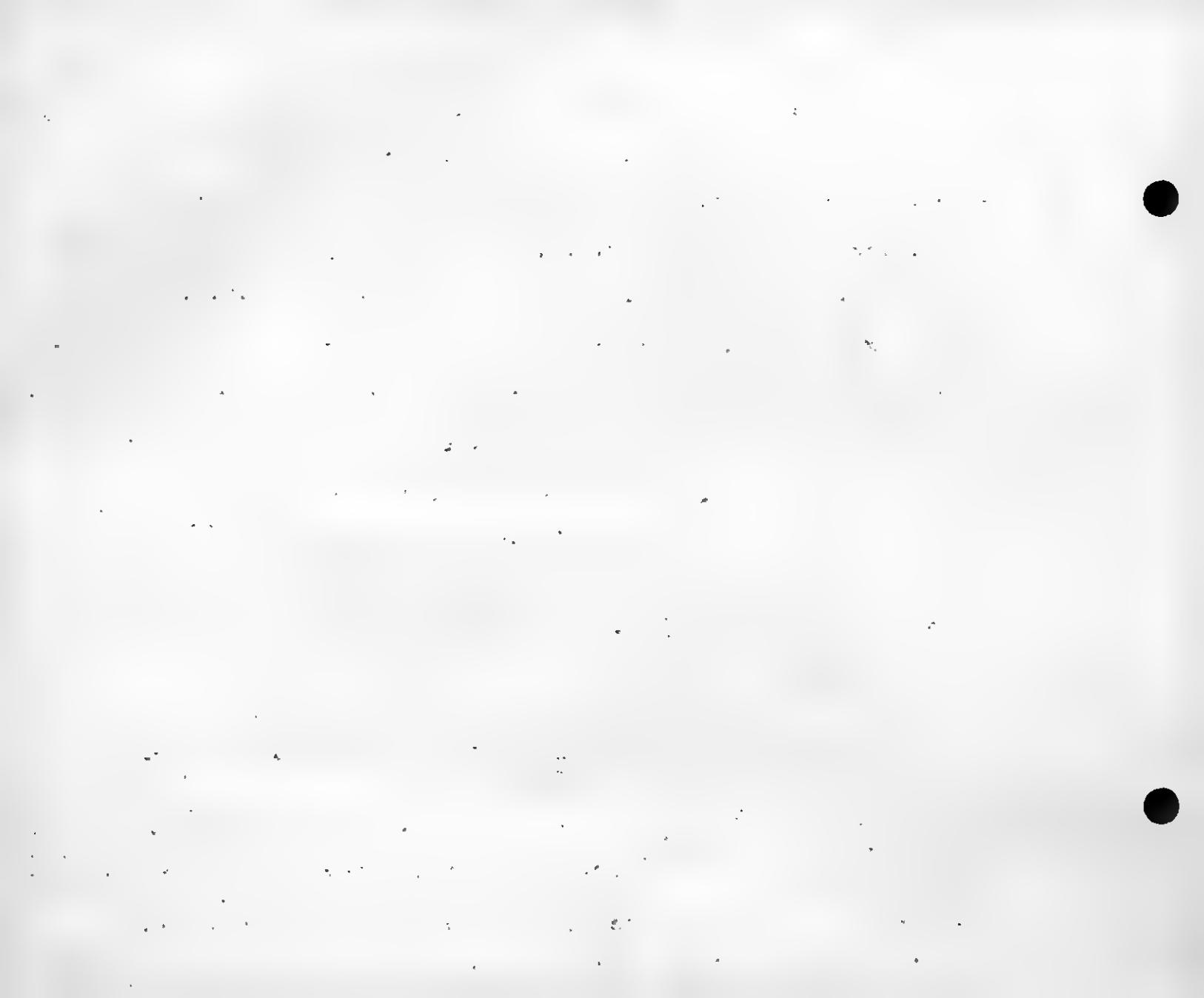
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First Catherine	Middle Rahauser	Lost Snavely	20. DATE OF DEATH Month 2 - Day 22 - Year 68	2b. HOUR 12:09
3. SEX female	4. RACE white	S. DATE OF BIRTH 6-25-1910	6. AGE (In years last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. 1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.	13b. COUNTY Wash.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER R.F.D. 1		
14. FATHER'S NAME First Elmer	Middle P.	15. MOTHER'S MAIDEN NAME First Eleanor	Middle -	Lost Nicodemus	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT Dr. Robert C. Snavely	Address Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction (starvation) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 mo DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause Abdominal Carcinomatosis 6 mo?					
DUE TO, OR AS A CONSEQUENCE OF (b) Adeno CARCINOMA of Breast 3 1/2 yrs. (c) Adeno CARCINOMA of Breast 3 1/2 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) 170					
19a. DATE OF OPERATION 1964	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Radical Mastectomy	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 19 68 to Feb 22 19 68 , that (I) (we) last saw the deceased alive on Feb 21 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard V. Hauver	DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22c. DATE SIGNED Feb 23, 68			
22d. PHYSICIAN'S NAME (Type) Richard V. HAUVER	22e. ADDRESS 247 N. Potomac Hagerstown, MD				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-24-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	23d. LOCATION (City or Town) Hagerstown, Md.	(County)	(State)
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. REC'D. BY REGISTRAR FEB 26 1968	25b. REGISTRAR'S SIGNATURE Charles J. Minnich		



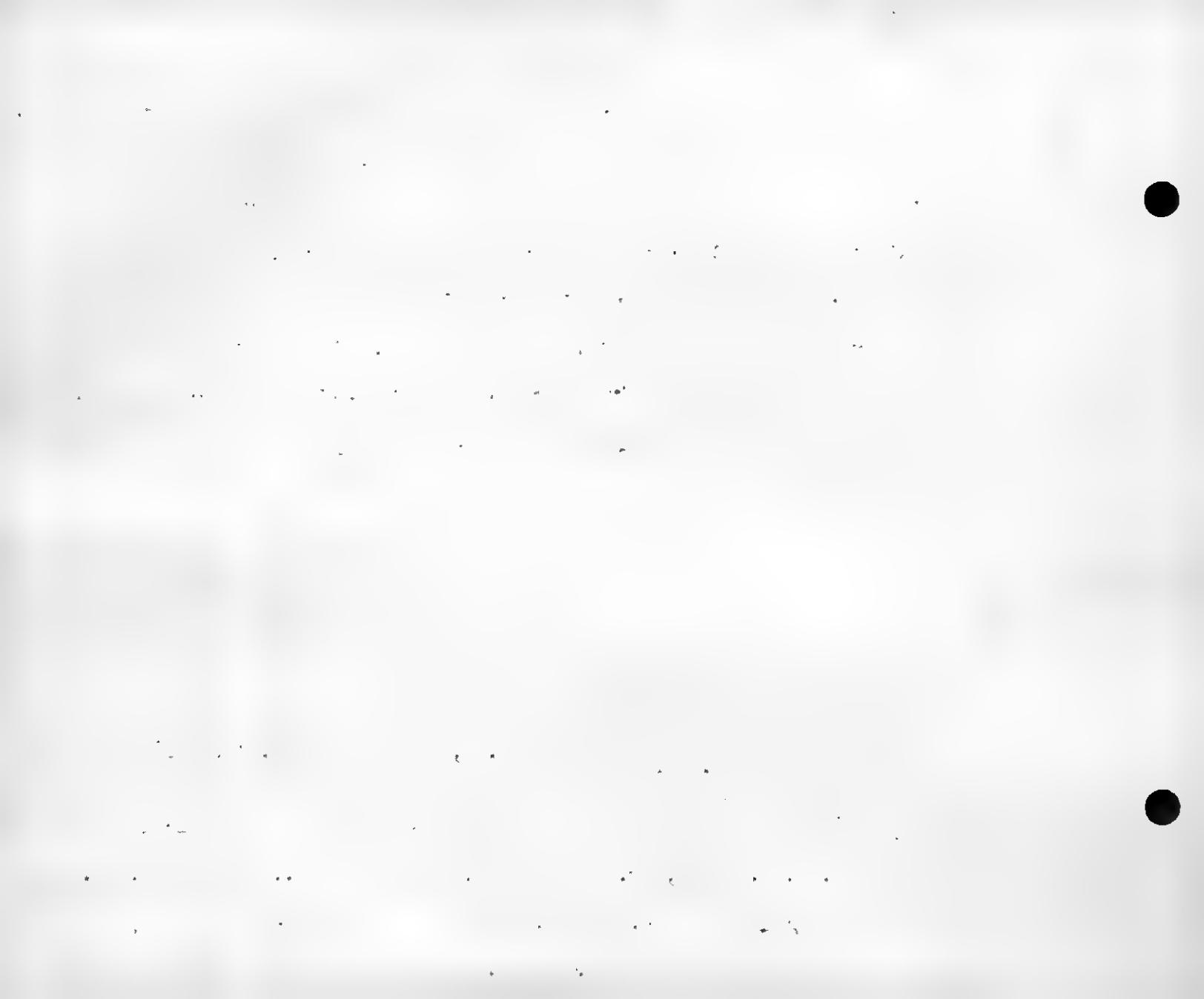
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 13e Film G398 3/6/68 ap CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First Helen	Middle Irene	Lost	2a. DATE OF DEATH Month 2 - Day 19 Year 1968	12.95 9:30 P.M.	
3. SEX female	4. RACE white	S. DATE OF BIRTH 2-16-1881	6. AGE (In years last birthday) 87 YRS	7. IF UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington			
10. CITY OR TOWN OF DEATH Hagerstown	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clearview Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY Wash.	13c. CITY OR TOWN Hagerstown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rt. 6 Hagerstown, Md.		
14. FATHER'S NAME First James	Middle -	Lost	15. MOTHER'S MAIDEN NAME First E. Alverda Smith	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16b. SOCIAL SECURITY NO. 214-09-7327	17. INFORMANT Mrs. Harwood Link	Address Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years
71 dy Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> lost.						
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 1, 1967, to Feb. 19, 1968, that (I) (we) last saw the deceased alive on Feb. 15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>E. W. Ditto, Jr.</i>	DEGREE ATTENDING PHYS.	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 2-20-68		
22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.	22e. ADDRESS 215 W. Washington St., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-22-68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery	23d. LOCATION (City or Town) Sharpsburg, Md.	(County)	(State)	
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles Jones	25b. REGISTRAR'S SIGNATURE			
DATE FEB 23 1968						



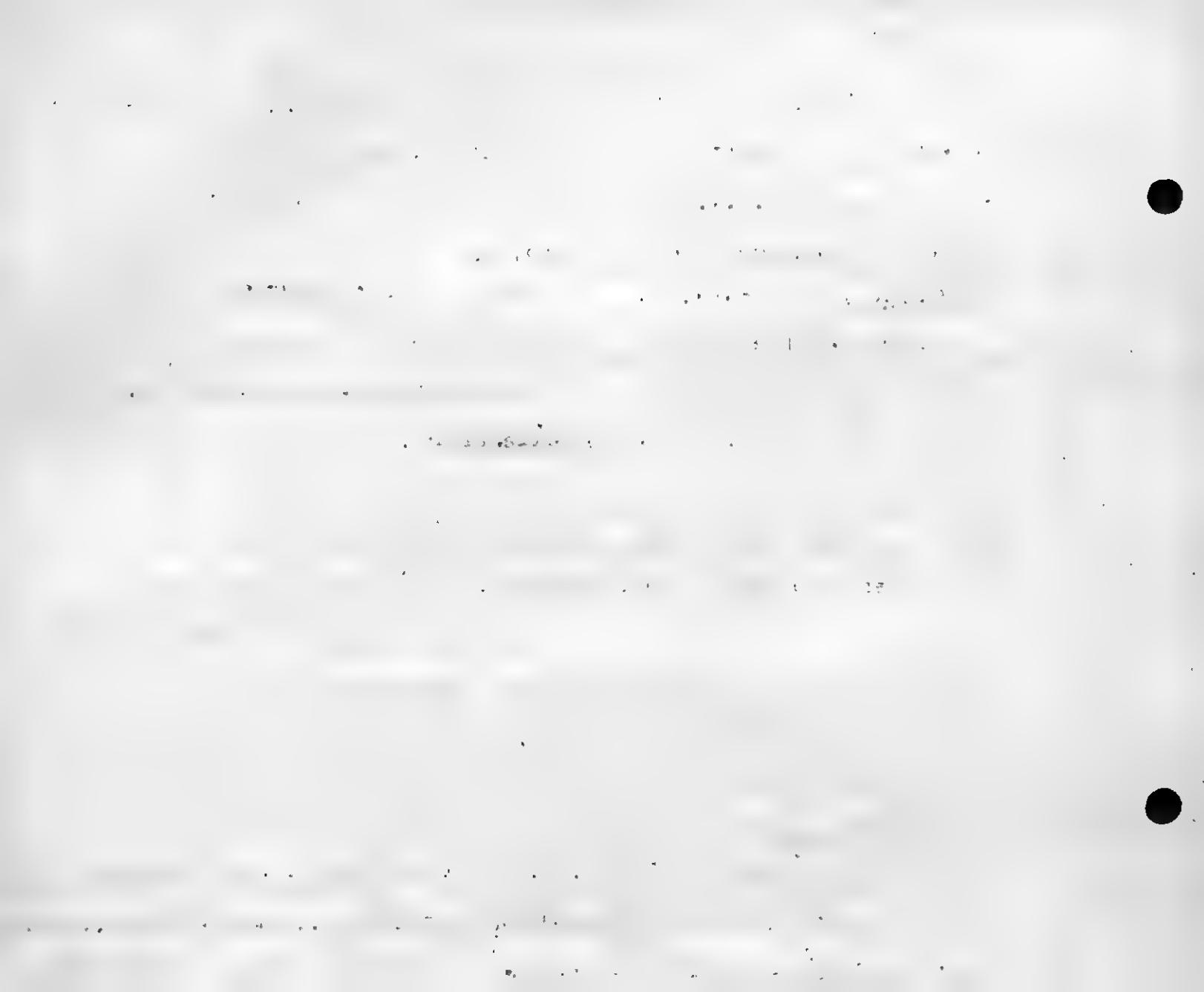
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR			
ELIZABETH ELIZA SNYDER						FEBRUARY	17,	1968		10:14			
3. SEX		4 RACE	5 DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					
FEMALE		WHITE	JULY 26, 1892			75	YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH							
PENNSYLVANIA		U.S.A.				WASHINGTON							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
HAGERSTOWN WASHINGTON COUNTY HOSPITAL					HOUSEWIFE								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
HAN MARYLAND		WASHINGTON	HANCOCK			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	BLUE HILL						
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
		JACOB MANNING						MARY	SMITH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
NO					GRACE IDEN RT. 1 HANCOCK, MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) • Pneumonia bilateral.											1 week		
4 OUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 490 x													
(b) DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
Arteriosclerotic heart disease with congestive failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No			City or Town		County	State		
22a. I certify that (I) (this hospital) attended the deceased from Feb 16, 1968, to Feb 17, 1968, that (I) (we) last saw the deceased alive on Feb 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Charles C. Spencer, M.D.</i>		22c. DEGREE ATTENDING PHYS			<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED Feb 18, 1968					
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			145 South Prospect Street								
CHARLES C. SPENCER, M. D.													
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION (City or Town)		(County)	(State)			
BURIAL		2/21/68		STONE BRIDGE CEMETERY RD., HANCOCK, WASH., MD.									
24. FUNERAL DIRECTOR		ADDRESS						25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE				
<i>Howard J. Glone</i>								DATE FEB 23 1968					

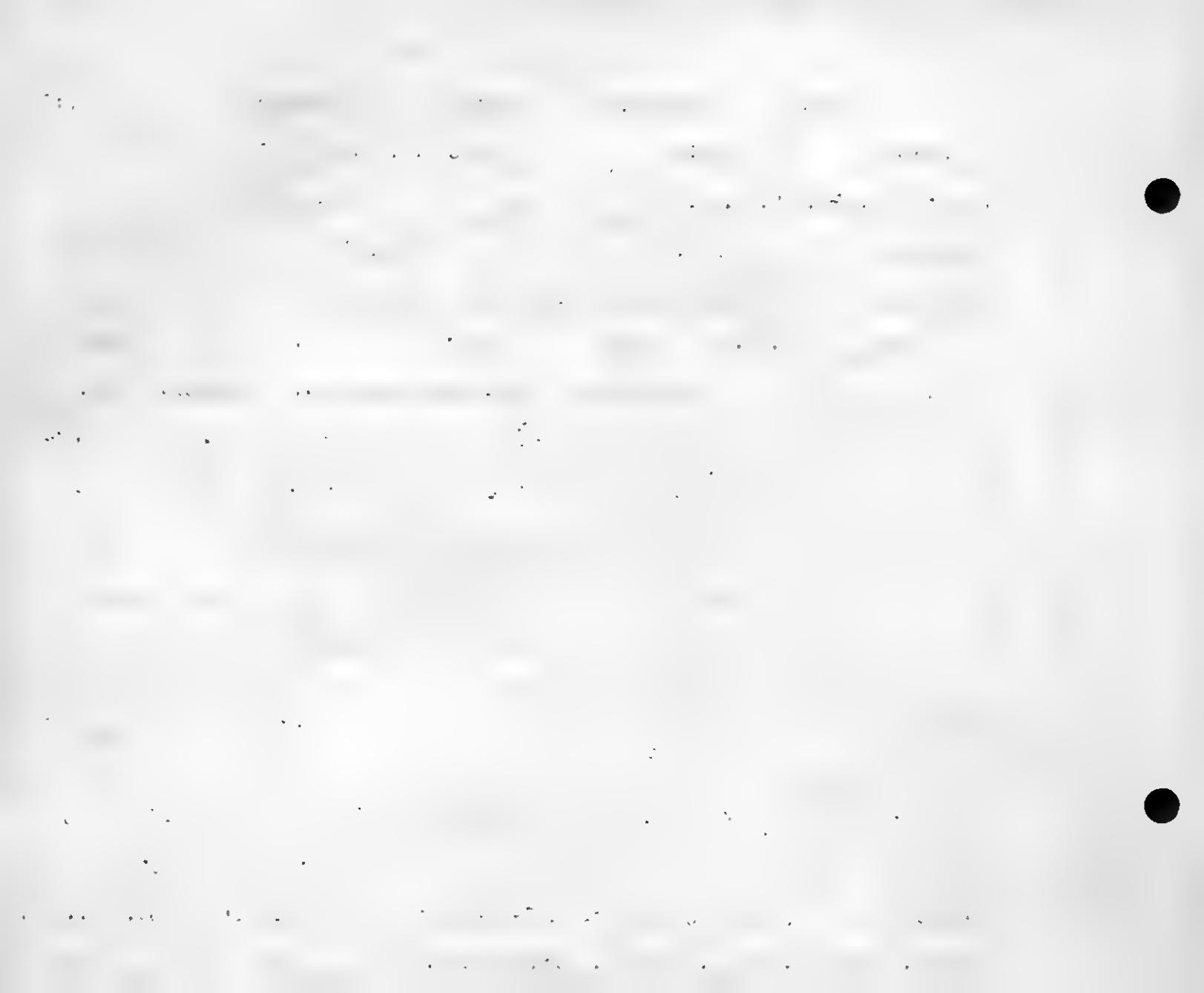


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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1. DECEASED-NAME (Type or print)	First Lenora	Middle Magdalene	Last Snyder	2a. DATE OF DEATH Month February	Day 19	Year 1968	2b. HOUR 7:00AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH August 14, 1878			6. AGE (In years last birthday) 89		
7a. BIRTHPLACE (State or foreign country) Locust Grove, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Washington	10a. CITY OR TOWN OF DEATH Boonsboro			10b. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife
10c. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	10d. COUNTY Washington	10e. CITY OR TOWN Boonsboro	10f. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	10g. STREET AND NUMBER Rfd. 1	12b. KIND OF BUSINESS OR INDUSTRY Own Home		
14. FATHER'S NAME First John	Middle A. B.	Last Potter	15. MOTHER'S MAIDEN NAME First Mary	Middle E.	Last Bealer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 217-56-0282	17. INFORMANT Mrs. Vera Baker, Rfd. 1, Boonsboro, Md.	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs		
DUE TO, OR AS A CONSEQUENCE OF (b) Massive cerebral Haemorrhage DUE TO, OR AS A CONSEQUENCE OF (c)					2 weeks		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4+ + 1							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from Feb 8, 1968 , to Feb 19, 1968 , that (I) (we) last saw the deceased alive on Feb 18, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G. W. Williams	DEGREE Attending Phys.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Feb 21, 1968			
22d. PHYSICIAN'S NAME (Type) G. W. Williams	22e. ADDRESS Boonsboro, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-21-68	23c. NAME OF CEMETERY OR CREMATORIUM Rohrersville Cemetery	23d. LOCATION (City or Town) Rohrersville Wash. Co., Md.	(County)	(State)		
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.	ADDRESS	25a. REC'D BY REGISTRAR Charles J. Babb	25b. REGISTRAR'S SIGNATURE				
DATE FEB 26 1968							

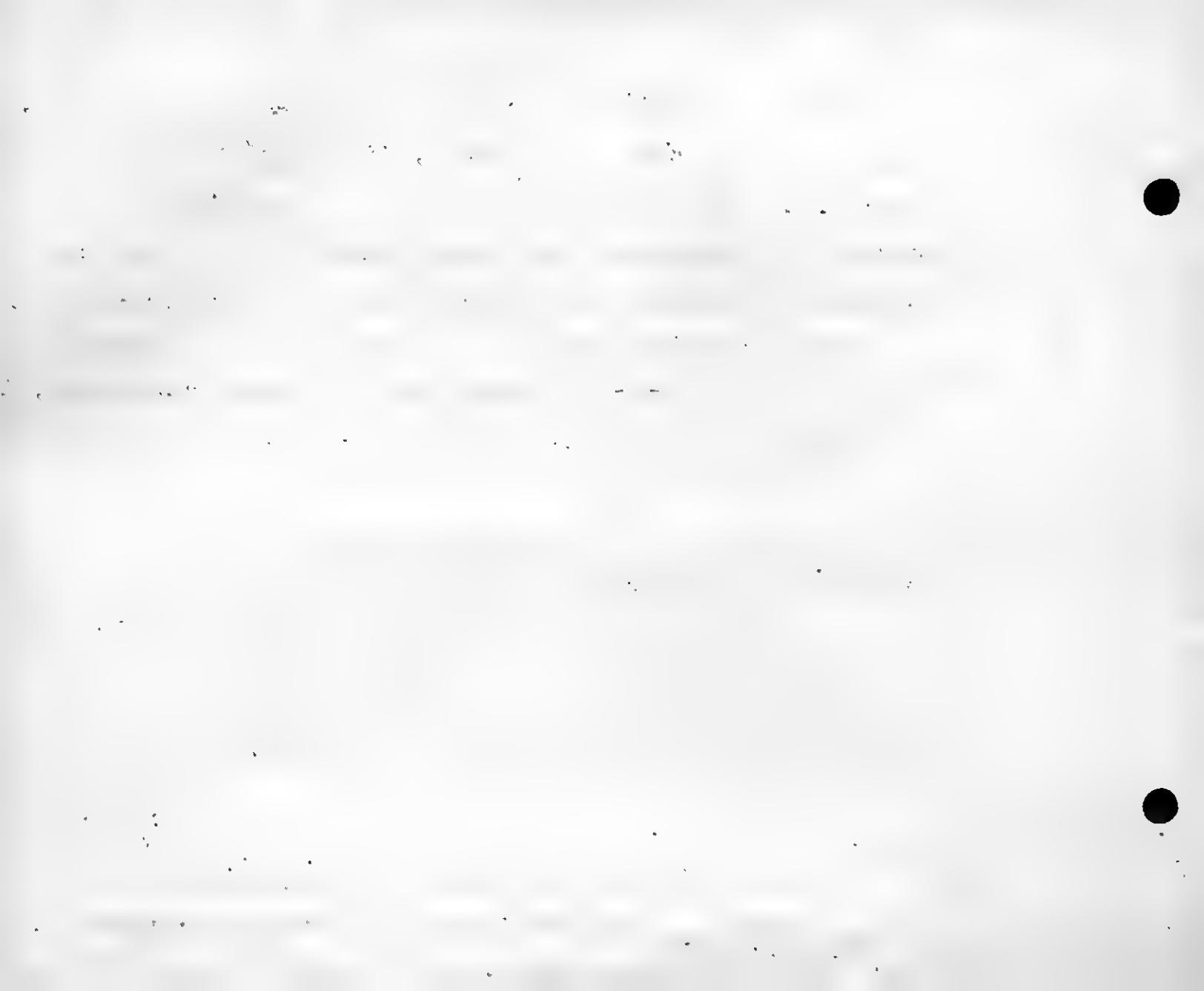


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. DECEASED-NAME (Type or print)	First Earl	Middle Franklin	Last Sypolt	2a. DATE OF DEATH Month February	Day 7	Year 1968	2b. HOUR 11:20 A.M.
3. SEX Male	4 RACE White	5. DATE OF BIRTH July 22, 1905		6 AGE (In years last birthday) 68 2		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) Roxbury, W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Glazier		12b. KIND OF BUSINESS OR INDUSTRY Wood Work	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 135 Randolph Ave.	
14. FATHER'S NAME First Charles		Middle Franklin	Last Sypolt	15. MOTHER'S MAIDEN NAME First Nora		Middle Aresman	Last
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no or unknown No		16b. SOCIAL SECURITY NO (If yes give war or dates of service) 214-09-0168		17. INFORMANT Charles Sypolt 135 Randolph Ave. Hagerstown, Md.		Address Martha	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma Right Bronchus</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last <u>1621</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Martha							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Congestive heart failure</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County
22a. I certify that (I) (this hospital) attended the deceased from <u>1/2/68</u> , 1968, to <u>2/1/68</u> , 1968, that (I) (we) last saw the deceased alive on <u>2/6/68</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. Mandell</u>		DEGREE ATTENDING PHYS	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS	22c. DATE SIGNED <u>2/7/68</u>		
22d. PHYSICIAN'S NAME (Type) A.M. MANDELL, M.D.		22e. ADDRESS <u>301 E. Antietam St.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/11/68		23c. NAME OF CEMETERY OR CEMETORY Rest Haven Cemetery		23d. LOCATION (City or Town) Hagerstown Washington Md.	
24. FUNERAL DIRECTOR <u>Wm. Q. Stort</u>		ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE <u>Wm. Q. Stort</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

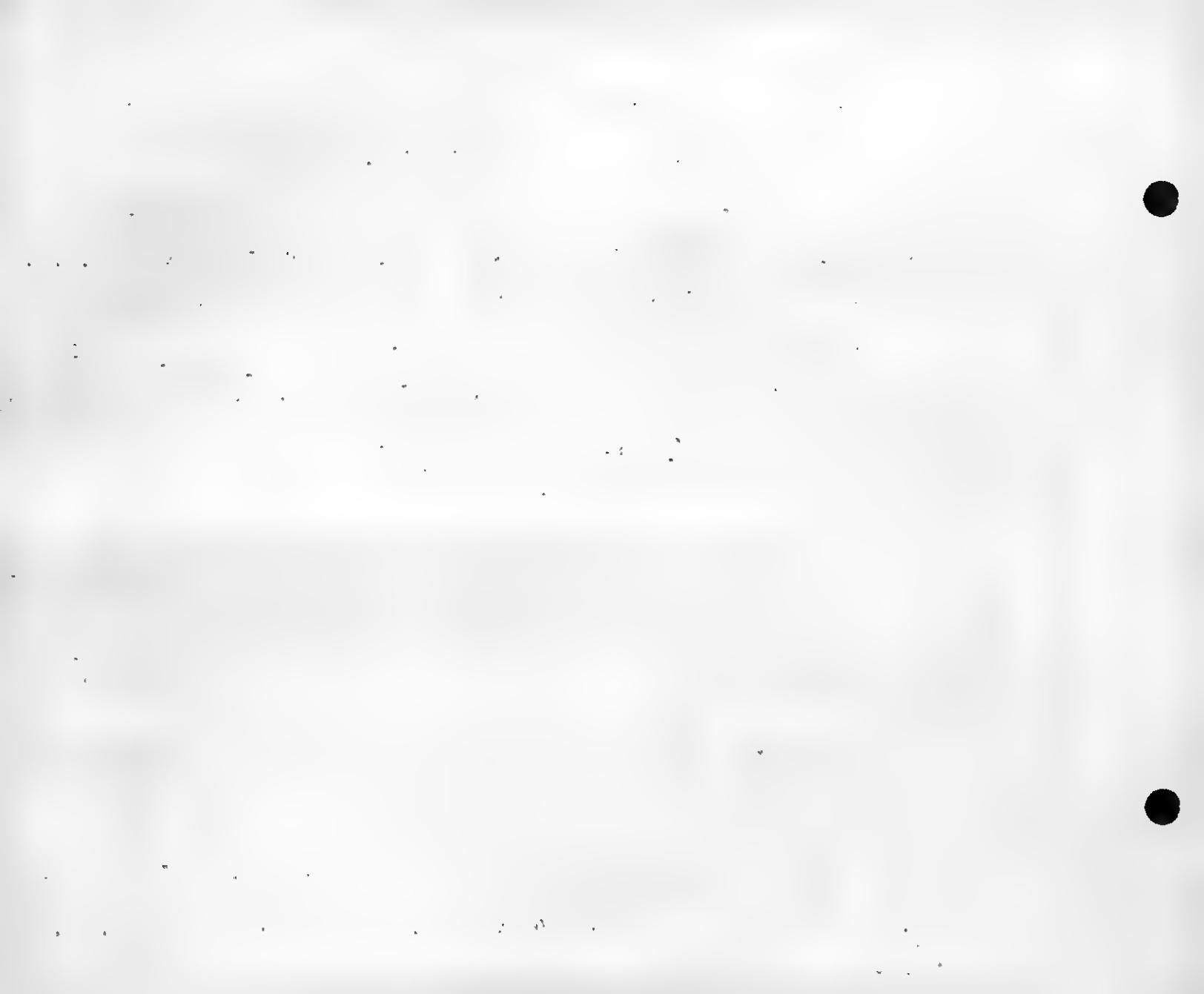
27.1

DECEASED-NAME (Type or print)	First LOWELL	Middle HOWARD	Last TAYLOR	2a. DATE OF DEATH Month 2 / Day 6 / Year 1968	2b. HOUR 5 PM					
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH SEPTEMBER 6, 1881		6. AGE (In years last birthday) 86 YRS.	IF UNDER MONTHS 0	YEAR 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	
7a. BIRTHPLACE (State or foreign country) KANSAS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH WASHINGTON	Md.						
10. CITY OR TOWN OF DEATH RURAL HAGERSTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2008 VIRGINIA AVENUE			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RET. RAILROAD CONDUCTOR U.S. GOVERNMENT	12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY WASHINGTON	13c. CITY OR TOWN HAGERSTOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 2008 VIRGINIA AVENUE						
14. FATHER'S NAME First BENJAMIN	Middle TAYLOR	15. MOTHER'S MAIDEN NAME First MARY	Middle BOONE		Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	16b. SOCIAL SECURITY NO. 220-10-3549	17. INFORMANT MISS JEANNETTE TAYLOR, HAGERSTOWN, MARYLAND.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i>										
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause <i>Arteriosclerosis</i>										
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral arteriosclerosis</i>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)										
332X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. 10 Month Jan Day 19 Year 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 115 W. WASHINGTON ST.	City or Town HAGERSTOWN		County WASH. CO.		State MD.		
22a. I certify that (I) (myself) attended the deceased from 1/26/68 to 2/6/68 , that (I) (we) last saw the deceased alive on Feb 6 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Eldon Hoachlander, M.D.</i>										
22c. DATE SIGNED 2/7/68										
22d. PHYSICIAN'S NAME (Type) ELDON D. HOACHLANDER, M.D.		22e. ADDRESS 115 W. WASHINGTON ST. HAGERSTOWN, MD.								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/9/68	23c. NAME OF CEMETERY OR CREMATORIAL REST HAVEN CEMETERY	23d. LOCATION (City or Town) HAGERSTOWN		(County) WASH. CO.		(State) MD.		
24. FUNERAL DIRECTOR <i>Charles D. Hoachlander</i>		ADDRESS HAGERSTOWN, MARYLAND.		25a. REGD. BY REGISTRAR FEB 13 1968	25b. REGISTRAR'S SIGNATURE <i>Charles D. Hoachlander</i>					

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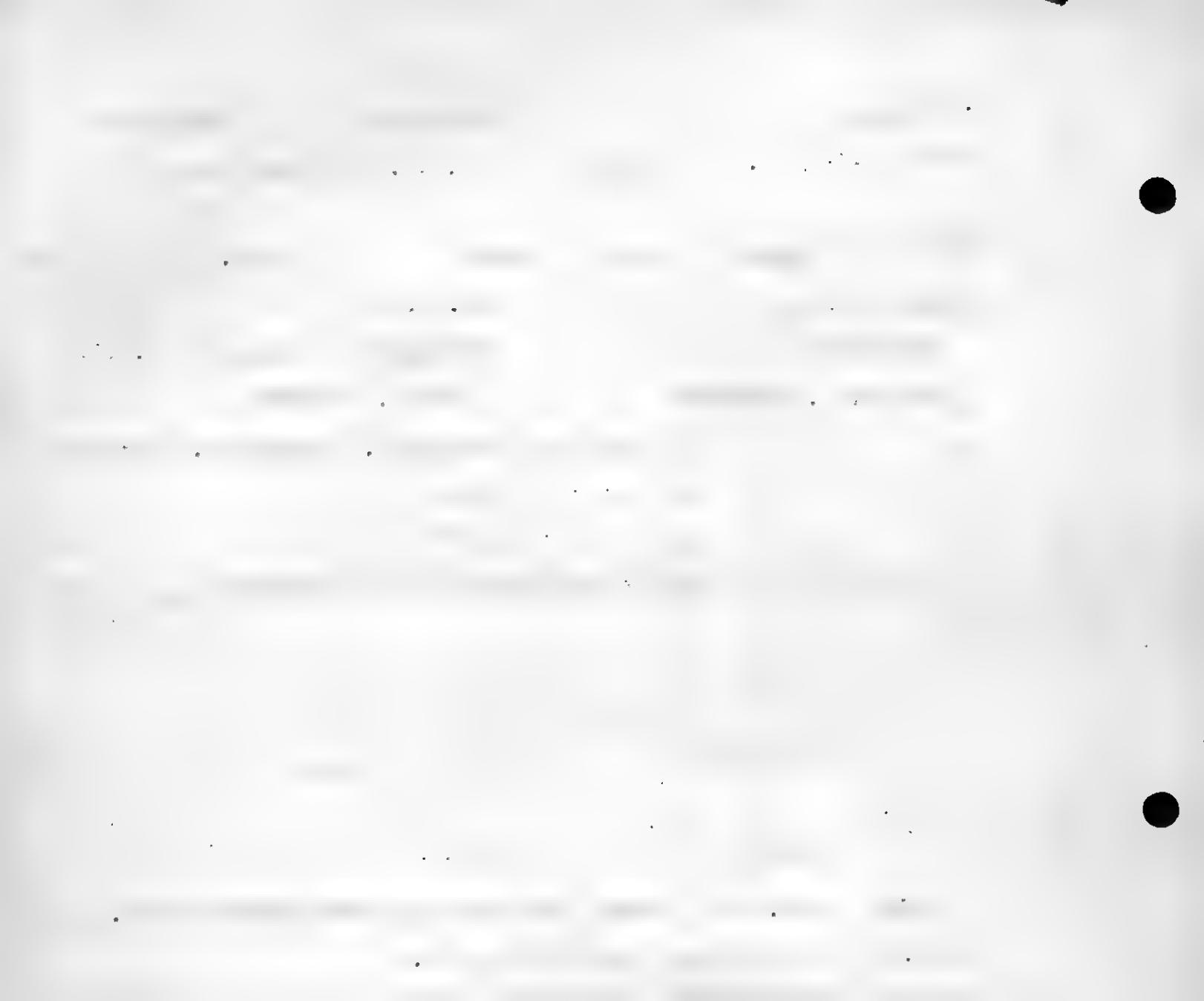
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Clear Spring Md.		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. 1, Clear Spring	
3. NAME OF DECEASED (Type or print) Rhoda		First Bell	Middle Tedrick
4. DATE OF DEATH Month Feb. 20		Day 1968	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct. 3, 1897		9. AGE (in years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months Days Hours Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William C. Hawbaker	14. MOTHER'S MAIDEN NAME Ida R. Forsythe
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-42-1409	17. INFORMANT Address William C. Tesrick Sr. Clear Spring
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation			
INTERVAL BETWEEN ONSET AND DEATH 5 minutes			
19. Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. Coronary artery Disease		DUE TO (b) 10 years	
20. DUE TO (c) Hypertensive arteriosclerotic heart disease		DUE TO (c) 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) <input type="checkbox"/> attended the deceased from 08/06/57 , 19, to 02/20/68 , 19, that (I) <input type="checkbox"/> last saw the deceased alive on 01/12/68 , 19, and that death occurred at 8:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED 02/22/68	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen		22d. ADDRESS M.D.	22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF Feb. 23, 68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Cedar Lawn Memorial Park Hagerstown Md.	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR Thompson Funeral Home		25a. REC'D BY REGISTRAR FEB 26 1968	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

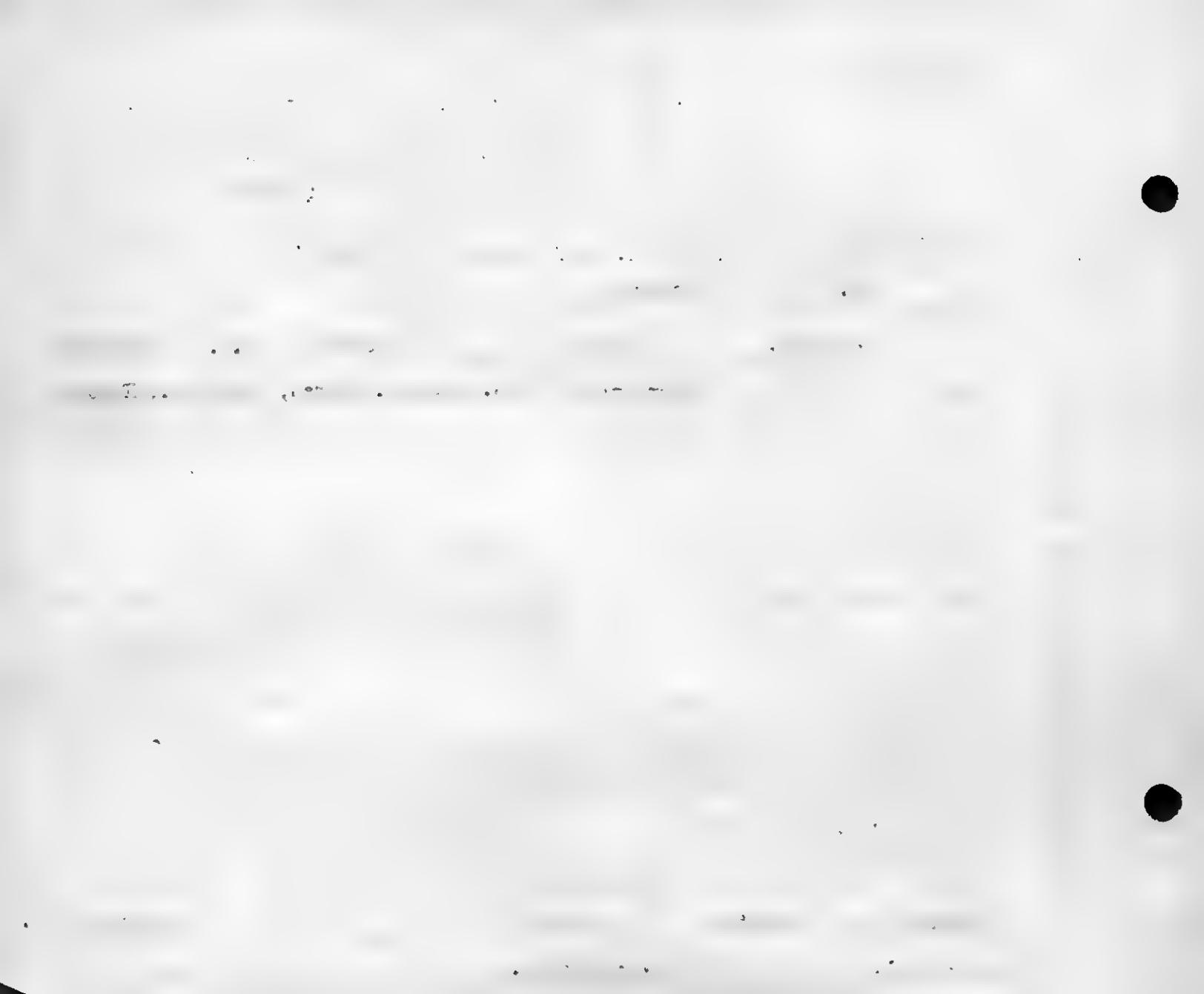


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03261

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First HARRY	Middle CLAYTON	Lost WARREN	2a. DATE OF DEATH Month FEBRUARY	Day 10	Year 1968	2b. HOUR 1:00 P.M.
3. SEX M	4. RACE W	5. DATE OF BIRTH 6-24-1900		6. AGE (In years last birthday) 67	YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0
7a. BIRTHPLACE (State or foreign country) PA.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH WASHINGTON				
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during rest of working life, even if retired) Electrician		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.	13b. COUNTY Frederick	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER			
14. FATHER'S NAME Charles F.	First Charles F.	Middle Warren	15. MOTHER'S MAIDEN NAME Sarah	First Sarah	Middle S.G.	Lost Tressler	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-09-1110	17. INFORMANT Mrs. Alice A. Warren, Lantz Md., Route #1	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) CARCINOMA LUNG		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 MOS.					
16/11 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. 0	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1968 , to 2-10, 1968 , that (I) (we) last saw the deceased alive on 2-9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE DOMINGO A. GARCIA				DEGREE ATTENDING PHYS.	ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED 2-10-68	
22d. PHYSICIAN'S NAME (Type) DOMINGO A. GARCIA	22e. ADDRESS WESTERN MARYLAND STATE HOSPITAL						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/12/68	23c. NAME OF CEMETERY OR CREMATORIAL Bethel		23d. LOCATION (City or Town) Washington Md.	(County) Washington	(State) MD	
24. FUNERAL DIRECTOR Robert V. Groves	ADDRESS Waynesboro Pa.	25a. REC'D. BY REGISTRAR DATE FEB 13 1968	25b. REGISTRAR'S SIGNATURE 0				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. DECEASED-NAME (Type or print)			First Mary	Middle Lela	Last Whitmore	2a. DATE OF DEATH Month 2 - Day 27 - Year 1968	2b. HOUR 11.00 A.M.
3. SEX female		4. RACE white		5. DATE OF BIRTH 11-24-1876		6. AGE (In years last birthday) 91	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wash		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 1536 Dual Highway
14. FATHER'S NAME William - Shuff			15. MOTHER'S MAIDEN NAME Mary			12b. KIND OF BUSINESS OR INDUSTRY Home	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Max Whitmore		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA RIGHT BASE 4868 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 483 X (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ATHEROSCLEROSIS CEREBRAL & GENERALIZED. CARDIOMEGALIA. CARDIOMEGALY							
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from Feb 22, 1968, to Feb 27, 1968, that (I) (we) last saw the deceased alive on Feb 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>William T. Layman, M.D.</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Feb 27 1968		
22d. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN, M.D.		22e. ADDRESS 100 Prof. Arts Bldg. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-29-68	23c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		23d. LOCATION (City or Town) Hagerstown, Md.	(County)	(State)
24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 29 1968	25b. REGISTRAR'S SIGNATURE <i>Charles J. Minnich</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03263

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First John	Middle Merlin	Last Wisherd	2a. DATE OF DEATH Month Feb Year 23 1968	2b. HOUR 1:00 P.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH December 21, 1893		6. AGE (In years last birthday) 74 yrs.		
7a. BIRTHPLACE (State or foreign country) San Mar, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Md. 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Salesman		12b. KIND OF BUSINESS OR INDUSTRY Building Supplies	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 208 East Irvin Ave.	
14. FATHER'S NAME Charles		Middle Wisherd	Last	15. MOTHER'S MAIDEN NAME Clara		Middle	Last Kaylor	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No.		16b. SOCIAL SECURITY NO. 217-18-7688		17. INFORMANT Mrs. Pauline S. Wisherd, 208 E. Irvin Ave.		Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <u>4109</u> (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u>								
19a. DATE OF OPERATION X MEDICAL CERTIFICATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 23, 1968</u> , to <u>Feb 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 23, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>G. W. Van</u>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <u>2/25/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>G. W. Van</u>		22e. ADDRESS <u>Boonsboro, Md.</u>						
23a. BURIAL, CREMATION, BURNING (If city) Burial		23b. DATE 2- 26- 68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Zion Cemetery		23d. LOCATION (City or Town) (County) San Mar Wash. Co., Md.			(State)
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS		25a. RECD. BY REGISTRAR FEB 28 1968		25b. REGISTRAR'S SIGNATURE <u>John H. Bast, Jr.</u>		
30M REV. 1/68		DATE						

recognition.